

# CliffsTestPrep®

## NCLEX-RN®

*An American BookWorks Corporation Project*

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### ***Authors' Acknowledgments***

American BookWorks Corporation would like to acknowledge and thank the contributions of Linda A. Razer to this project.

### ***Publisher's Acknowledgments***

#### ***Editorial***

**Acquisition Editor:** Greg Tubach

**Project Editor:** Kelly D. Henthorne

**Copy Editor:** Katie Robinson

**Technical Editor(s):** Karen Pulido

#### ***Composition***

**Proofreader:** Jennifer Connolly

Wiley Publishing, Inc., Composition Services

### **CliffsTestPrep® NCLEX-RN**

Published by:

**Wiley Publishing, Inc.**

111 River Street

Hoboken, NJ 07030-5774

www.wiley.com

Copyright © 2005 Wiley, Hoboken, NJ

Published by Wiley, Hoboken, NJ

Published simultaneously in Canada

ISBN-13: 978-0-7645-7288-3

ISBN-10: 0-7645-7288-1

Library of Congress Control Number is available from the publisher.

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

1B/QY/QT/QV/IN

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# Introduction

The NCLEX-RN examination has recently been updated and revised. This book has been written to help you prepare for—and pass—that exam. The NCLEX (National Council Licensure Examination) is required in order for you to obtain a license to practice as a registered nurse. The exam is administered by the National Council of State Boards of Nursing and ensures that your license is acceptable throughout the entire United State and its territories.

By passing this test, you will be able to practice as a registered nurse. The test itself is based on the specialized knowledge that you should have at this point, and it tests your skills and ability to meet the various requirements that will be required within the nursing process. Because this is a test of basic competency, you will be able to demonstrate your abilities as an entry-level nurse on this exam. It is not a test for the more experienced nurse, because you will not encounter questions about more sophisticated elements of the nursing profession, nor is it an indicator of how you will fare in the profession.

During the examination, which is computerized, you will answer anywhere from 75 to 265 questions, so there is a limit to the amount of material that will be covered on the test. In this book, we've tried to give you as much material as possible, based on previous tests, and, of course, these questions are written by nurse-educators, who are familiar with this version of NCLEX-RN and who teach their students with the goal of passing this exam.

## The CAT Exam

---

You probably are aware that the NCLEX-RN is computerized. Sometimes the exam is called a CAT (Computerized Adaptive Testing) test, because the computer *adapts* to your responses. You begin with a moderately difficult question, and if you answer it correctly, the next question will be slightly more difficult. If you answer incorrectly, the next question will be slightly easier. Essentially, the computer is selecting questions based on your abilities. The more questions you answer, the more the computer understands your responses and can tailor the questions for you. Thus, if you answer most of the questions correctly, you may have to answer only 75 questions, because they have increased in difficulty from the first question onward. If you have trouble with a large number of questions, the computer keeps trying easier questions until you answer correctly. At the most, you will be asked to answer 265 questions.

You cannot skip questions as you work through the test, since each question is predicated on the previous response. So you will have to spend time working on each question. However, if you can't deduce the answer in any logical way, select any answer to move on to the next one. The next one will be easier and perhaps will restore your confidence.

The entire testing period is five hours. This includes a brief tutorial, sample questions, and scheduled breaks during the testing period.

## How to Use This Book

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This book contains a series of eight chapters, each chapter containing questions based on the latest format of the exam. We cover the following topics, based on what are known as Client Needs categories. There are four basic Client Needs categories, and as you can see, two of these categories are broken down into six subcategories. All of the topics and subtopics are covered in this book, although many of them may be combined into similar topic areas.

- Safe and Effective Care Environment
  - Coordinated Care
  - Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity

- Basic Care and Comfort
- Pharmacological Therapies
- Reduction of Risk Potential
- Physiological Adaptation

In addition, we've also included answers and explanations that will help you understand the material in greater depth. We've explained not only the correct answers, but in most cases, we've tried to help you understand why the other choices were incorrect. Because the answers are presented right after the questions in the review chapters, you will have immediate feedback to the questions. You should, of course, know much of this material already, but there are certainly a lot of topics that you might not be as familiar with as some of the others that are presented in this book. The process is to read the question, try to understand what they're asking of you, try to determine the answer, and then check the answer that accompanies that question.

Furthermore, certain important concepts are integrated throughout the Client Needs categories and subcategories:

1. **Nursing Process.** This is the scientific approach to client care that includes data collection, planning, and implementation and evaluation.
2. **Caring.** This is the interaction between you, as the registered nurse, and the clients, their families, or their significant others. Client care requires mutual respect and trust.
3. **Communication and Documentation.** It is of utmost importance that you are able to be clear and concise in your interactions with those of the families as well as those of others on your healthcare team. This requires the ability to communicate both verbally and nonverbally and to be accountable in keeping and maintaining records and patients' charts.
4. **Teaching and Learning.** You must demonstrate the appropriate skills and attitudes that promote changes in yourself and others, by learning and teaching. Being an effective RN requires the ability to share information with clients and their families.

## About the Content

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As mentioned, there are eight Client Needs chapters, and within those chapters are individual subcategories, for which you'll be responsible. Following is a list of all of the Client Needs chapters and the percentage of questions that will appear on the test, as well as the subcategories. Keep in mind that other material might be covered on the test.

### **Safe and Effective Care Environment**

#### **Coordinated Care (13–19%)**

Advance Directives

Advocacy

Client Care Assignments

Client Rights

Collaboration with Multidisciplinary Team

Concepts of Management and Supervision

Confidentiality

Consultation

Continuity of Care

Delegation

Establishing Priorities

Ethical Practice

Informed Consent

Legal Rights Responsibilities

Performance Improvement (Quality Assurance)



Referral Process

Resource Management

Staff Education

Supervision

**Safety and Infection Control (8–14%)**

Accident/Error Prevention

Disaster Planning

Emergency Response Plan

Error Prevention

Handling Hazardous and Infection Materials

Home Safety

Injury Prevention

Medical and Surgical Asepsis

Reporting of Incident/Event/Irregular Occurrence/Variance

Safe Use of Equipment

Security Plans

Standard/Transmission-Based/Other Precautions

Use of Restraints/Safety Devices

**Health Promotion and Maintenance (6–12%)**

Aging Process

Ante/Intra/Postpartum and Newborn Care

Data Collection Techniques

Developmental stages and Transitions

Disease Prevention

Expected Body Image Changes

Family Planning

Growth and Development

Health and Wellness

Health Promotion

Health Screening

High Risk Behaviors

Human Sexuality

Immunizations

Lifestyle Choices

Principles of Teaching/Learning

Self-Care

Techniques of Physical Assessment

**Psychosocial Integrity (6–12%)**

Abuse or Neglect

Behavioral Interventions

Chemical Dependency

Coping Mechanisms

Crisis Intervention

Cultural Diversity

End-of-Life Concepts  
Family Dynamics  
Grief and Loss  
Mental Health Concepts  
Psychopathology  
Religious or Spiritual Influences on Health  
Sensory/Perceptual Alterations  
Situational Role Changes  
Stress Management  
Support Systems  
Therapeutic Communication  
Therapeutic Environment  
Unexpected Body Image Changes

**Physiological Integrity**

**Basic Care and Comfort (6–12%)**

Alternative and Complementary Therapies  
Assistive Devices  
Elimination  
Mobility/Immobility  
Non-Pharmacological Comfort Interventions  
Nutrition and Oral Hydration  
Palliative/Comfort Care  
Personal Hygiene  
Rest and Sleep

**Pharmacological Therapies (13–19%)**

Adverse Effects/Contraindications and Side Effects  
Blood and Blood Products  
Central Venous Access Devices  
Dosage Calculations  
Expected Effects  
Intravenous Therapy  
Medication Administration  
Pharmacological Agents/Actions  
Pharmacological Pain Management  
Total Parenteral Nutrition

**Reduction of Risk Potential (13–19%)**

Diagnostic Tests  
Laboratory Values  
Monitoring Conscious Sedation  
Potential for Alterations in Body Systems  
Potential for Complications of Diagnostic Tests/Treatments/Procedures  
Potential for Complications of Surgical and Health Alterations  
Therapeutic Procedures  
Vital Signs

**Physiological Adaptation (11–17%)**

Alterations in Body Systems

Fluid and Electrolyte Imbalances

Hemodynamics

Illness Management

Infectious Diseases

Medical Emergencies

Pathophysiology

Radiation Therapy

Unexpected Response to Therapies

All of the topics and subtopics are covered in this book, although many of them may be combined into similar topic areas.

## Types of Questions

Most of the questions are multiple choice with four options. There are, however, other types of questions, such as fill-in-the-blanks, and even identifying items with “hot spots.” What this means is that you’ll be given an illustration, table, or perhaps a chart, and you have to click on it with the on-screen cursor to identify the correct answer. Because it’s computerized, the machine can identify the spot where you’ve clicked. We’ll cover more of these later in this introduction.

## The Multiple-Choice Format

Most of the standardized tests that you’ve probably taken throughout your educational career have contained multiple-choice questions. For some reason, these types of questions give a large percentage of test takers a difficult time. If you approach these questions carefully, they should be easier than you think.

Let’s analyze the concept of the multiple-choice question. Keep in mind that these questions are created to test your ability to recognize the correct answer from four choices. From the start, you should be happy that there are only four choices, not five, as there are on many exams. This reduces the number of incorrect options.

Questions are comprised of several parts:

- The question stem
- The correct choice
- Distracters

As test-item writers create questions, they normally approach it as follows:

- One choice is absolutely correct.
- One or two choices are absolutely incorrect.
- One or two choices may be similar to the correct answer but might contain some information that is not quite accurate or on target, or even might not answer the specific question (often called distracters).

How do you approach the questions? First, read the question and see whether you know the answer. If you know it automatically, you can look at the choices and select the correct one. Let’s look at a very simple example here.

1. Mammography is used to detect which of the following conditions?

1. pain
2. tumor
3. edema
4. epilepsy

This should be a very simple and clear question and answer. It's a question that most lay people would know, without the benefit of a nursing school education. You should know that mammography is used to detect tumors or cysts in the breasts. It is not used to detect any of the other conditions. Of course, you should know that a mammogram is the image produced by a low-dose x-ray of the breast.

If you don't know the answer, you have certain options, using the time-honored approach of process of elimination. Are there any choices that you can immediately eliminate? For example, choice 1 is not likely to be identified by mammography. It's possible that a patient experiencing pain comes for a mammogram to identify the source of the pain, but it cannot "see" pain. Thus, you can eliminate that answer. Now you've improved your odds of answering the question correctly. Instead of having only a 25 percent chance (one out of four choices) to identify the correct answer, you now have a 33 percent chance (one out of three choices).

After you've eliminated this one, move to the next choice. It's possible that mammography is used to locate tumors. (Yes, we know this is the correct answer, but the exercise here is to demonstrate how to eliminate the choices if you didn't know that answer.) The next choice is edema. If you know that edema is a swelling caused by an abnormal accumulation of fluid in body tissues, you might think it possible that a mammogram can spot the fluid and that might be a possible answer. Hold on to that choice for a moment and move to choice 4, epilepsy.

Epilepsy is a disorder of the central nervous system, and you should know this. Is it possible for a mammogram to spot a nervous disorder? This can't be a correct choice if you know that a mammogram is an x-ray. So you can eliminate that choice also.

This leaves only two choices—tumor or edema. At this point, if you really don't know the answer, you have to guess. But at this stage, having eliminated two very clear incorrect choices, you have a 50 percent chance (one out of two choices) to guess the correct answer.

It is important to read the questions carefully. Look at the following example:

- 2.** All of the following should be done when fetal heart monitoring indicates fetal distress except:
- 1.** increasing maternal fluids.
  - 2.** administering oxygen.
  - 3.** decreasing maternal fluids.
  - 4.** turning the mother.

How did you answer this question? Did you take note of the word "except?" All of the choices are correct except for choice 3. This is the only intervention that should *not* be done when fetal distress is indicated.

Finally, pay attention to words like *always*, *never*, or *not*. Most things in the world are not *always* or *never*, and you should be careful if a question asks you to choose which of the choices is *not*. . .! Or, like the question above, "All are correct *except*. . .!"

Some of the questions might ask you about measurements. For example, there is a big difference between 0.401, 4.01, 40.1, and 401. Keep things like decimal points in mind as you read these types of questions. Make sure, also, that you know your measurements like liters and milliliters, fluid ounces, and so on.

As you go through this book, take your time with the questions and answers. Try to analyze what you answered incorrectly and learn from the answers. Identify those questions where you were able to use the process of elimination. Check how well you did on those. How many did you just know and were able to answer? Don't just worry about how well or poorly you did. Take the time to do an analysis of your results.

These are the secrets to being a successful test taker. Obviously, you must be armed with an education and have the knowledge and skills to be able to take the test. You will, however, have a better chance if you practice the techniques of answering multiple-choice questions.

## Alternate Forms of Questions

As we mentioned briefly, most of the questions in the test will be multiple-choice questions with four choices. However, because of the power of the computer, you will also encounter some alternate forms of questions:

1. Multiple-choice questions that may have more than one correct choice. However, unlike the regular four-choice questions, you will likely see a prompt that will tell you to choose or select all that apply. There may be more than four choices in these questions.
2. Fill-in-the-blank questions where you'll be asked to type a specific number or word.
3. Calculation or ordered response question that will require you to either do some computing or itemize the items presented in the correct order.
4. "Hot spot" items that will ask you to identify with the cursor the appropriate area on a picture or other graphic on the screen.

Why do they give you these types of questions? It is believed that you will be able to develop your competence in certain areas, beyond which multiple-choice questions cannot test. If, for example, you are asked to do a problem that requires calculations, by actually doing them yourself, you will prove yourself more capable than merely selecting the correct answer from four choices (especially since you've learned the secrets of answering these types of questions earlier in this section).

## Alternative Response Items

### Multiple Choice Problems

1. The nurse is caring for a client with tuberculosis. Which of the following infection control precautions should the nurse implement? Select all that apply.

- ☐ 1. Wear a particulate respirator mask when entering the client's room.
- ☐ 2. Wear a gown when assessing the client's peripheral pulses.
- ☐ 3. Wear gloves when checking the client's blood pressure.
- ☐ 4. Wear sterile gloves when taking the client's oral temperature.
- ☐ 5. Place the client in a reverse air flow room.

2. A diabetic client receives his morning insulin, but then eats only half of his breakfast. A few hours later, the client complains of a headache and weakness. Which of the following interventions should the nurse implement? Check all that apply.

- ☐ 1. Give the client another dose of insulin.
- ☐ 2. Check the client's blood glucose.
- ☐ 3. Have the client exercise.
- ☐ 4. Offer the client some orange juice.
- ☐ 5. Encourage the client to eat a snack.

### Fill-in-the-Blank (Calculation)

3. The physician orders a client to receive cefazolin sodium (Kefzol) 500 mg IM now. The nurse has 250 mg/ml available. How many milliliters will the nurse give?

- 4.** The nurse is completing the intake and output record for a client who had a thoracotomy with chest tube placement. The client had the following intake and output during the eight-hour shift.

Intake:	6 oz. of tea
	1 cup of diced chicken salad
	8 oz. of water
	$\frac{1}{2}$ cup of green beans
	4 oz. of sherbet
	1000 ml of D5 $\frac{1}{2}$ NS IV fluid
Output:	1200 ml of urine from the urinary drainage bag
	50 ml of drainage from the chest tube

How many milliliters should the nurse document as the client's intake?

### Fill-in-the-Blank (Ordered Response)

- 5.** A nurse enters a client's hospital room and discovers the client is cyanotic and is not breathing. Place the interventions the nurse should perform in the order of priority.

1. Place the client on a cardiac monitor.
2. Call for help.
3. Check for a pulse.
4. Open the airway.
5. Begin cardiac compressions.

Insert your answer here: \_\_\_\_\_

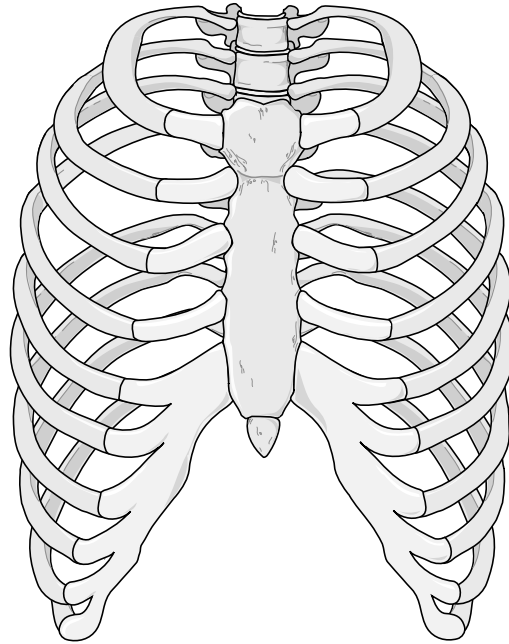
- 6.** A client walks into the emergency room stating he has just been stabbed in the neck. The nurse notes that he is bleeding heavily from the right side of the neck. Put the nursing interventions in the correct order that the nurse should perform them.

1. Administer a tetanus vaccine.
2. Check the client's blood pressure.
3. Apply pressure to the site of bleeding.
4. Prepare the client for suturing by the physician.

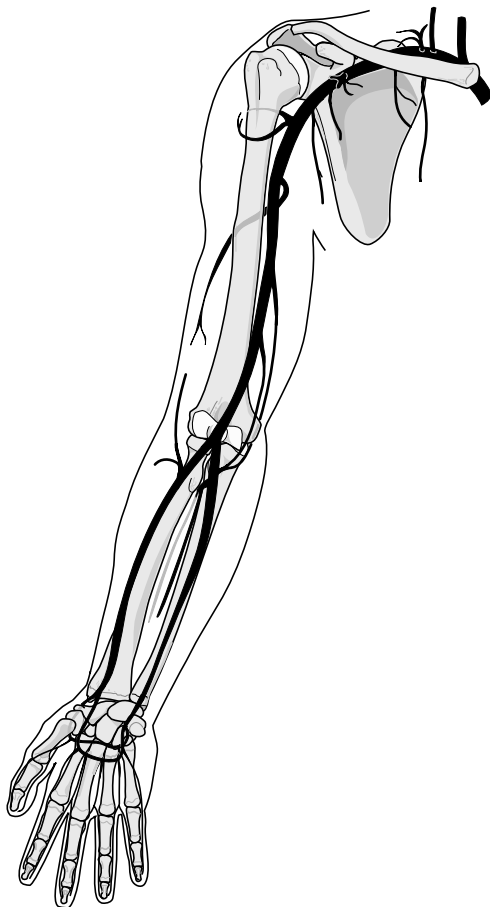
Insert your answer here: \_\_\_\_\_

## Hot Spot

7. Identify the area the nurse would place her stethoscope to best auscultate a cardiac murmur associated with mitral valve regurgitation.



8. The nurse is assessing a client's peripheral pulses. Identify the area the nurse should place her fingers in order to palpate the radial pulse.



## Answers and Explanations

1.

- ☒ 1. Wear a particulate respirator mask when entering the client's room.
- ☐ 2. Wear a gown when assessing the client's peripheral pulses.
- ☐ 3. Wear gloves when checking the client's blood pressure.
- ☐ 4. Wear sterile gloves when taking the client's oral temperature.
- ☒ 5. Place the client in a reverse air flow room.

A special particulate mask is needed to filter out the small size bacteria of tuberculosis, which is spread by inhaling respiratory droplets. A gown is not necessary to wear for assessing pulses, because there is no spread of tuberculosis by contact. Gloves are not needed to check blood pressure, because tuberculosis is not spread by contact with skin. The nurse does not need to wear sterile gloves when taking an oral temperature; clean gloves will suffice if there will be potential contact with saliva, which is assumed to be a potential contaminant in all clients. The client is placed in a reverse air flow room, so that bacilli are not carried via the air into the hallway, to potentially expose other people to tuberculosis.



2.

- ☐ 1. Give the client another dose of insulin.
- ☒ 2. Check the client's blood glucose.
- ☐ 3. Have the client exercise.
- ☒ 4. Offer the client some orange juice.
- ☒ 5. Encourage the client to eat a snack.

The client should not be given another dose of insulin, as this would make the blood sugar drop even further. The blood glucose should be checked in order to determine how hypoglycemic the client is. The client should not exercise at this time, as that would lower the blood sugar further. Offering the client orange juice and a snack will allow intake, which will elevate the blood sugar.

3. 2 ml

$$\frac{250 \text{ mg}}{1 \text{ ml}} \times \frac{500 \text{ mg}}{x \text{ ml}} = 2 \text{ ml}$$

4. 1540

Chicken salad and green beans are solid food, so they do not count as fluid intake. Sherbet, when melted, is liquid, so it counts as a fluid.

There are 30 cc per ounce.

$$6 \times 30 = 180$$

$$8 \times 30 = 240$$

$$4 \times 30 = 120$$

$$\text{IV} = \frac{1000}{1540}$$

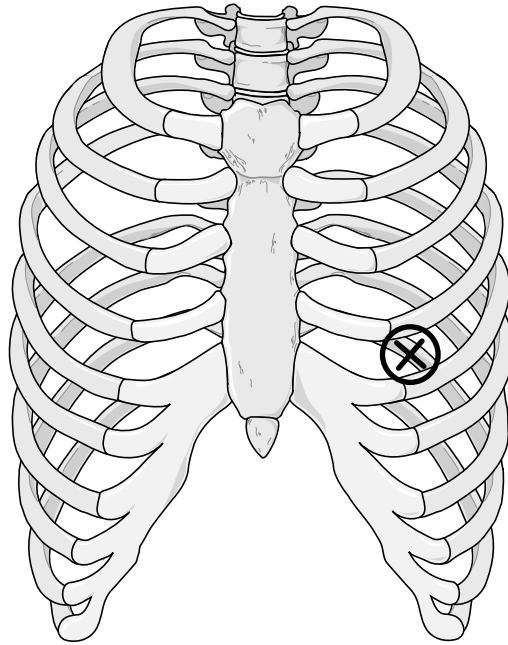
5. 2, 4, 3, 5, 1

When the nurse is in an agency setting, she should call for help first, so that other personnel can respond to assist. The airway is opened next, followed by checking for a pulse (A-B-C; airway-breathing-circulation). If there is no pulse, then cardiac compressions are started by one nurse, while another nurse prepares to place the client on a cardiac monitor to determine the cardiac rhythm.

6. 3, 2, 4, 1

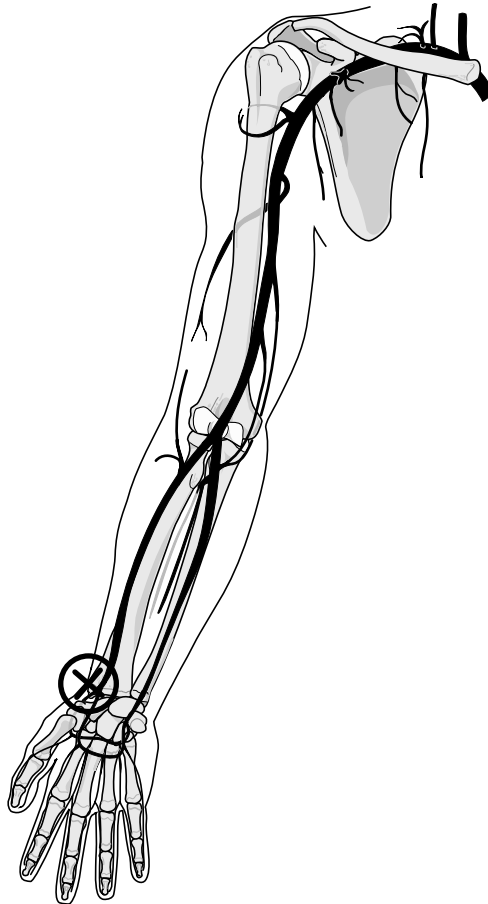
This is a question that measures your ability to prioritize nursing interventions. Pressure is first applied to the site of bleeding, in order to stop or at least slow the bleeding, to prevent further blood loss. Blood pressure is checked, to determine if the client may be developing shock due to such large amount of blood loss. The client is then prepared for suturing, whether in the ER, or if needing to be taken to the OR. A tetanus vaccine is given last, as it is least priority.

7.



The murmur associated with mitral valve regurgitation is auscultated at the fifth intercostal space at the midclavicular line. Other areas for cardiac auscultation are associated with other cardiac valves.

8.



The radial pulse is palpated over the radial artery, which is located on the thumb side of the hand, at the wrist. The ulnar artery is located on the little finger side of the hand. The brachial artery is located at the inner elbow.

How did you do? As you can see, these questions are not particularly difficult, but do require you to do a little more work. If you know the material, you should have no trouble with these questions.

## Scoring High on the NCLEX-RN

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In order to do well on this exam, you can take several steps.

First, make sure that you understand the material. How do you do that? Recognize that this test is a minimum-skills test and does not require you to use high-tech information or knowledge of information that an experienced registered nurse already possesses. Go back to your nursing school notes. And most important, use this book. It's been set up in such a way that you can continually check your understanding of the material by providing the answers to each and every question.

Second, be diligent in your studying. Go through each chapter and answer the questions. Then see how you did after each question. Did you understand the question? Did you know the answer immediately, or did you have to use the process of elimination?

Third, take the practice tests. Although the actual NCLEX-RN is a computerized CAT exam, it is still helpful to take a pen-and-pencil test. Yes, you will have to answer the full complement of 265 questions this way, but it serves a couple of purposes. You will be able to get an idea of what it's like to take an NCLEX-RN test, and you will be exposed to more than 1,250 additional questions among these five exams—and acquire the understanding of the material that's presented here.

When taking these tests, set yourself up in a quiet room under test-taking conditions. Time yourself and see how long it takes to answer all of them. Although the actual test experience is five hours, remember that some of that time is taken up by a tutorial, review practice exams, and breaks. Give yourself a break after taking a third of the test (after about 88 questions). Get up and walk around, have a glass of water, and then return to the test. If you don't need the break, keep going.

After you've completed the test, take a break and come back to it the next day after you've given yourself a rest. Then check the answers. After receiving a score, go back to those that you had incorrect and try to understand why they were wrong. Did you make careless errors? Did you understand the topic?

On the actual test, work steadily. Keep in mind that you can't skip questions on the computer, so you're forced to provide an answer, whether you know it or not. In a paper-and-pencil test, you can always skip a question and return to it later on. Don't spend too much time on any one question, or you'll never get through the test. If it's correct, so much the better, but if not, you'll get an easier question. Don't let your confidence flag. You've studied for the exam; you've taken practice tests; and you know the material. There will always be questions that you don't know, but you have to do the best that you can and continue to believe in your ability to answer as many questions as possible correctly.

The NCLEX-RN is a pass-fail examination. As we said earlier, you will be expected to answer from 75–265 questions. As you progress through the exam, the computer evaluates your progress and will continue to present you with questions until you've demonstrated—with 95 percent certainty—that your ability is above or below a passing standard. The score is not just based on the number of questions that you've answered, but rather on the level of difficulty of the questions, although you will have to answer correctly approximately 50 percent of the questions you have received. There are exceptions to this rule, however, and in some cases, if you have not demonstrated with 95 percent certainty that you are clearly above or below the passing standard, the computer can evaluate your pattern of responses. If you have demonstrated a consistent pattern above the passing standard, you will pass the exam.

## Study Plan

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There really is no correct way to study. However, if you expect to do well on the test by cramming in the last week prior to the exam, you probably won't do very well. The only way to prepare is to follow a sensible study plan that you can create yourself. We suggest reading through the book, chapter by chapter and answering the questions as you go along and then reading the explanations for the answers. In this way, you'll be reviewing material that you probably know already, and at the same time, learning some information that may have passed you by.

Since there are eight basic chapters in the book, if you can spend one week per chapter, you'll have plenty of time to absorb the material. At the end of that time, you should take the practice tests—one day to take a test and one day to check your answers. You don't need to take each test one after the other.

Based on these suggestions, if you can plan a 12-week study period, you should be able to get through everything in this book within reason.

Finally, keep a record of those questions with which you had trouble. When you've completed the entire chapter, go back and review them again.

Good luck on the exam!

**PART I**

# **SUBJECT AREA REVIEW CHAPTERS**



# Coordinated Care

This chapter contains questions and answers from the following topic areas:

- Advance Directives
- Advocacy
- Client Care Assignments
- Client Rights
- Collaboration with Multidisciplinary Team
- Concepts of Management and Supervision
- Confidentiality
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Legal Rights Responsibilities
- Performance Improvement (Quality Assurance)
- Referral Process
- Resource Management
- Staff Education
- Supervision

**1.** The intent of the Patient Self Determination Act (PSDA) of 1990 is to:

1. enhance personal control over legal care decisions.
2. encourage medical treatment decision making prior to need.
3. give one federal standard for living wills and durable powers of attorney.
4. emphasize patient education.

(2) The purpose of the PSDA is to promote decision making prior to need. The focus of the PSDA is healthcare decision making. A federal standard for advance directives does not exist. Each state has jurisdiction regarding these policies and protocols. The PSDA emphasizes the need for patient education in order to support an individual's treatment decisions.

**2.** The advanced directive in your patient's chart is dated August 12, 1998. The patient's daughter produces a Power of Attorney for Healthcare dated 2003 that contains different care direction(s). As the nurse you are to:

1. follow the 1998 version because it's part of the legal chart.
2. follow the 1998 version because the physician's "code" order is based on it.
3. follow the 2003 version, place it in the chart, and communicate the update appropriately.
4. follow neither until clarified by the unit manager.

(3) The document dated 2003 supersedes the previous version and should be used as a basis for care direction. Choice 1 and 2 are incorrect as the 1998 version is now outdated. Choice 4 is incorrect; the nurse could be held negligent for not responding to the 2003 document as directed.

- 3.** An advance directive is written and notarized according to law in the state of Colorado. This document is legal and binding:
1. internationally.
  2. in the state of Colorado only.
  3. in the continental United States.
  4. in the county of origination only.

(2) Choices 1, 3, and 4 are incorrect; advance directive protocols and documents are defined by each state.

- 4.** The authority conveyed to a Power of Attorney is revocable by:
1. a primary care physician.
  2. a court proceeding.
  3. the family if all members agree.
  4. the person who originally delegated the authority following proper documentation procedures.

(4) Only the person who delegates authority has the legal right to revoke the authority. Choices 1, 2, and 3, therefore, are incorrect.

- 5.** Copies of advance care directives should be:
1. kept in a safe or safe deposit box only.
  2. given to the attorney responsible for preparing the documents.
  3. provided to each healthcare institution upon entry for services.
  4. kept as private and confidential documents.

(3) Each healthcare facility is required to have advance directives on file. Choices 1, 2, and 4 are incorrect as advance directives are not considered confidential information. They are to be shared information in order to ensure their direction will be followed.

- 6.** The legal age for expressing one's wishes through an advance directive is:
1. 21 years.
  2. 18 years.
  3. 65 years.
  4. Any age.

(2) Eighteen years of age is the minimum legal age for establishing advance directives.

- 7.** A patient is "competent" when he/she is:
1. able to understand risks and benefits of treatment options and manipulate the information rationally.
  2. able to sign a consent form.
  3. is oriented to person, place, and time.
  4. is able to physically take care of him/herself.

(1) 2, 3, and 4 are incorrect. An individual can sign his name on a form without higher level comprehension of what he is signing, it's appropriateness, and so on. Orientation is one aspect of cognitive function that does not support decision making, concrete thinking, and problem solving. An individual may be able to perform basic activities of daily living (ADLs) but still have impaired thought processes, judgment, and decision making, which are also important factors in competency determination.



**8.** The night before an elective surgery, a client asks the nurse why he was asked to complete an advance directive on admission. The nurse's best response is:

1. "It's just a formality."
2. "This form helps the care team understand your wishes so we won't be sued."
3. "It is a legal requirement that all clients entering the hospital have the opportunity to express their wishes through an advance directive."
4. "Are you worried that you might not live through your surgery?"

**(3)** All patients entering the hospital for any reason are asked to complete advance directives according to JCAHO standards. Choices 1, 2, and 4 are incorrect. Advance directives are more than a formality as they give guidance to treatment based on the individual's wishes. The guiding ethical principle is patient autonomy, not liability protection for the healthcare providers. Choice 4 is an inappropriate response by the nurse as it reflects that she did not understand or interpret the patient's original question.

**9.** As the nurse caring for Mrs. Peet, you discover during her admission assessment that she does not have advance directives. She asks whether there are any specific rules about naming a Durable Power of Attorney for Healthcare (DPOAHC) or document requirements. You accurately answer:

1. "A person designated DPOAHC must be a family member."
2. "A DPOAHC must be a lawyer."
3. "The DPAOHC document must include the name, address, and contact information of the party named."
4. "The individual named as DPOAHC must agree with the designee's decisions."

**(3)** The document records contact information of the party named. Choice 1, 2, and 4 are incorrect. A person named as a DPOAHC can be anyone of choice. That person does not have to be any personal or professional relation. The DPOAHC does not have to agree with the designee's decisions but be willing and able to speak for them should decisions regarding care be needed.

**10.** For individuals who are no longer capable of speaking for themselves, the order of surrogacy for their healthcare decision making is:

1. guardian, DPOAHC, spouse, adult children of patient, parents of patient, adult brothers and sisters of patient.
2. spouse, DPOAHC, parents of patient, adult children of patient.
3. DPOAHC, spouse, adult children of patient, adult brothers and sisters of the patient.
4. spouse, guardian, adult children of patient, DPOAHC.

**(1)** Choices 2, 3, and 4 are incorrect according to state law definitions.

**11.** In the relationship between DNR orders and advance directives (AD), all of the following are true except:

1. an AD may help a physician decide whether a DNR order is the "right" decision for a particular patient.
2. it can be assumed that a patient with an AD is a DNR.
3. an AD is not necessary in order for a physician to write a DNR order (with the exception of New York State).
4. a hospital-based DNR order should not require the patient's or family's signature but does require the physician's signature.

**(2)** It is NOT a correct assumption that a patient with an AD is a DNR. Choices 1, 3, and 4 are true as written.

**12.** Patient self-determination is the primary focus of:

1. malpractice insurance.
2. nursing's advocacy for patients.
3. confidentiality.
4. healthcare.

(2) Advocacy for patients by nurses is centered around the patient's right to autonomy and self-determination. Confidentiality involves the maintenance of the privacy of the patient and information regarding them. Malpractice insurance is a type of insurance for professionals.

**13.** The nurse acts as an advocate for the nursing profession by all of the following except:

1. encouraging political involvement by nurses with their legislators.
2. acting as a first-aid provider for a children's athletic team.
3. precepting newly licensed nurses in the work situation.
4. encouraging as many persons to become nurses as possible.

(4) The nurse acts as an advocate for the nursing profession by encouraging appropriate persons to become nurses, by being a positive role model and mentor, and by communicating the needs of nurses to those making the laws in the most professional manner possible.

**14.** A nursing advocate is one who:

1. makes decisions for others.
2. encourages people to make decisions for themselves and acts with or on their behalf to support those decisions.
3. manages the care of others.
4. is the legal representative for a person.

(2) Nurse advocates work with patients to provide information and assistance in decision making. The decisions and care that occur from these decisions are based on the right of the patient to self-determination and the work of the nurse advocate supports this right.

**15.** All of the following support the nurse as a patient advocate except:

1. ANA Code of Ethics for Nurses.
2. institutional review boards for the protection of human subjects engaged in research.
3. federal nurse practice acts.
4. JCAHO.

(3) Nurse practice acts are based in state law, not federal law, as mandated for the advocacy of nurses; JCAHO, ANA, and institutional review boards all support nurse advocacy.

**16.** An ombudsman is:

1. an individual, usually an employee of the government or an institution, who investigates consumer complaints and assists in achieving a fair resolution.
2. a lawyer designated to try a case.
3. an individual hired by a family as their representative.
4. a family member designated to make decisions for an individual.

(1) An ombudsman is an individual who works for the government or an institution to investigate consumer complaints. The goal of the ombudsman is fair investigation, reporting, and resolution of the complaint.

**17.** In addition to a nursing advocate, an older adult might utilize which of these advocacy groups?

1. AARP
2. Gray Panthers
3. National Committee to Preserve Social Security and Medicare
4. all of the above

(4) Any and all of these organizations provide advocacy services to older persons.

**18.** Advocacy is defined as:

1. helping another.
2. arguing, supporting, or defending a client's cause.
3. the principle of doing no harm.
4. a duty to do good.

(2) The definition of advocacy is to argue, support, or defend a client's cause. Providing assistance is helping another; the principle of doing no harm is nonmaleficence; beneficence is the duty to do good.

**19.** When patients cannot make decisions for themselves, the nurse advocate relies on the ethical principles of:

1. justice and beneficence.
2. fidelity and nonmaleficence.
3. beneficence and nonmaleficence.
4. fidelity and justice.

(3) When a patient is not autonomous, the nurse must rely on the principles of doing no harm and doing good, or non-maleficence and beneficence, in order to assist in meeting the healthcare needs of the person to the best of the nurse's ability.

**20.** Client advocates might include all of the following except:

1. creditors.
2. family members.
3. nurses.
4. social workers.

(1) Family members, healthcare professionals, ombudsmen, and persons designated as such, act as advocates for clients and patients.

**21.** Political action committees in nursing organizations act as advocates:

1. for legislators.
2. for members of the nursing organizations.
3. for clients.
4. for collective bargaining or union groups.

(2) Nursing organizations utilize political action committees within their organizations in order to represent the needs of their membership to legislative and organizational persons.

**22.** In an acute care hospital, the patient might expect which persons to act as advocates for him/her?

1. the nurse
2. the social worker
3. the physical therapist
4. all members of the interdisciplinary team caring for the patient

(4) In a healthcare setting, all members of the interdisciplinary team are expected to act as advocates for the patient.

**23.** A nurse case manager's focus is:

1. nursing care needs only on discharge.
2. the comprehensive care needs of the client for continuity of care.
3. patient education needs upon discharge.
4. financial resources for needed care.

(2) By definition, case management is a process of providing for the comprehensive care needs of the client for continuity of care through the healthcare experience.

**24.** The physician's role in case management includes all of the following except:

1. participate in interdisciplinary planning for patients.
2. serve as the expert for resource utilization.
3. consult with the case management team in order to facilitate timely orders as needed.
4. contribute to the documentation of the patient's needs for services.

(2) The physician is an integral part of the case management process in terms of assisting with defining the patient's needs and the time frames for movement through the healthcare system; however, the physician is the expert for medical diagnosis and treatment rather than resource utilization.

**25.** A case management clinical pathway for congestive heart failure might include all of the following except:

1. physician follow-up appointments with transportation.
2. patient education regarding medication usage.
3. nutritional consult for diet review and accommodation.
4. insurance review for reimbursement.

(4) Clinical pathways include maps of care outcomes to be achieved prior to discharge or movement through a healthcare system. Insurance review for reimbursement is a function of an outside agency from the healthcare provider related to the amount of expected monetary compensation for services rendered to a patient.

**26.** Case management involves which disciplines for effective planning?

1. nursing, therapy, social work
2. nursing only
3. nursing, medicine, therapy, social work
4. an interdisciplinary team including medicine and nursing based upon the patient's individualized needs

(4) The correct team for case management will include those professionals whose expertise is needed to meet the continuity of care needs of the patient.

**27.** An 80-year-old client is being discharged from the hospital after a total knee replacement. Her only son has decided to take care of her at his home. During discharge planning, it is most appropriate for the nurse to ask the son:

1. "Are you sure this is the best thing for you to do?"
2. "Will caring for your mother affect your lifestyle?"
3. "Do you own your own car?"
4. "Is your home paid off?"

(2) This open-ended question allows the son to express his thoughts and feelings regarding his mother's needs for care and changes that he may expect while he is providing this care. Information on his personal financial situation (ownership of home or car) or questioning his decision making in taking his mother home does not contribute to the plan of care.

**28.** Case managers work in which of the following settings?

1. hospitals and insurance companies
2. nursing homes only
3. community agencies
4. all of the above

(4) Case managers work in many different healthcare sites in order to encourage continuity of healthcare and provide services to a diverse group of clients.

**29.** Community-based case management has the goal of:

1. utilizing only community-based agencies.
2. optimizing health for community-based individuals.
3. only completing discharge plans from the hospital-based case manager.
4. managing illness-related states while excluding health promotion and wellness concerns.

(2) Community-based case management has the goal of support and empowerment of individuals to reach their optimal level of wellness through the use of community resources.

**30.** Case managers functions encompass a variety of roles including all of the following except:

1. financial planner.
2. clinical expert.
3. patient educator.
4. outcomes manager.

(1) Financial planning for individuals is not a role of a case manager. Case managers function as clinical experts, organizers of care, patient educators, monitors and evaluators of outcomes, and patient advocates.

**31.** The effect of managed care in healthcare systems has been to:

1. decrease length of stay in hospitals.
2. support the increased use of new technology.
3. focus care strategies on outcomes of care provision.
4. all of the above.

(4) Managed care has decreased the length of stay in hospitals, increased the use of home care services, encouraged technology use, and assisted in focusing healthcare on outcomes management.

**32.** The sequence of the case management process used by nurses is:

1. implementation, coordination, planning, evaluation, assessment, and monitoring.
2. assessment, planning, implementation, coordination, monitoring, and evaluation.
3. assessment, planning, coordination, implementation, monitoring, and evaluation.
4. assessment, planning, evaluation, coordination, monitoring, and implementation.

(2) The correct sequence of the case management process is assessment, planning, implementation, coordination, monitoring, and evaluation of care.

**33.** Case management processes are guided by:

1. standards of professional care.
2. protocols of healthcare delivery.
3. guidelines for clinical practice.
4. all of the above.

(4) Standards of professional care, protocols for healthcare delivery, clinical guidelines and pathways, law, and facility protocols all guide case management processes.

**34.** The patient's right to refuse to participate in research involves which of the following?

1. research on a new cancer medication
2. research on a new walker by physical therapy
3. research into the body's hormonal response to stress
4. all of the above

(4) The patient's right to refuse to participate in research extends to all types of research.

**35.** Mr. H. is upset regarding being in the hospital for another day because he states it costs too much. The rights that he may be expressing includes all of the following except:

1. the right to examine and question the bill.
2. the right to reasonable response to requests.
3. the right to refuse treatment.
4. the right to confidentiality.

(4) Confidentiality is the maintenance of privacy of information, which has not been breached. He is expressing the other rights and might exercise them in choosing to leave the hospital early, by requesting to see the actual costs of his care, and by requesting reasonable responses to his requests.

**36.** You and a colleague are on the elevator after your shift, and you hear a group of healthcare givers discussing a recent patient scenario. Which patient right might be breached?

1. right to refuse treatment
2. right to continuity of care
3. right to confidentiality
4. right to reasonable responses to requests

(3) The right to confidentiality of patient information might have been breached when patient care situations are discussed in public areas or without regard to maintaining the information as private and confidential. The other rights listed have not been breached in this instance.

**37.** Your patient requires an injection to maintain therapeutic levels of the medication. The client does not want the medication, but you give the medication per physician's order. You have violated which patient right?

1. Privacy.
2. Consideration and respect.
3. Refusal of treatment.
4. You have violated no patient rights as the medication was ordered by the physician.

(3) The right to refuse treatment is the patient right violated and exists even when the medication is ordered by a physician.

**38.** The nurse notices that a family is waiting at the nursing station desk for their loved one to be brought to the unit for admission during a change-of-shift report. The nurse:

1. requests that the family wait for their loved one in the patient's room and waits to resume the report until the family has left the desk area.
2. requests that a nursing assistant bring coffee for the family while they wait at the desk and continues with report.
3. requests that the family have a seat in the station rather than stand while awaiting their loved one.
4. requests that the family wait for their loved one in the emergency room waiting room.

(1) In order to protect the privacy of the patients and the confidentiality of the information shared in report, the family should be asked to wait in the patient's room, and the report should be resumed only after they can no longer hear it.

**39.** Our mother is being admitted to the hospital for elective surgery tomorrow. She has specifically not shared information regarding this event with her friends. Her best friend calls and says she knows something is terribly wrong. You have the right and duty to:

1. confirm her suspicions.
2. discuss your mother's upcoming surgery with her friend.
3. help your mother's friend to plan a homecoming party for your mother.
4. maintain your mother's privacy and the confidentiality of her medical information.

(4) Every patient has the right to privacy and to the confidentiality of their medical information. Even as her daughter, you do not have the right to discuss her medical care unless given permission by her to do that.

**40.** Your patient is being discharged from the hospital today. She has the right to expect:

1. a continuity of care plan will be initiated prior to discharge from the hospital.
2. all medical information will be available to her son after her discharge.
3. her bill will be sealed and unchangeable after discharge.
4. the information regarding her diagnosis and treatment will be given to her pastor when he comes to visit her before her discharge today.

(1) Medical information is not shared with family or clergy persons unless permission is given by the patient. Your patient has the right to examine and question her bill, even after discharge, and so the bill is open to change if needed after discharge. Your patient should expect a continuity of care plan to be initiated prior to discharge and communicated with her.

**41.** Your patient will be undergoing surgery in the morning. Ways in which you might support her patient rights include all of the following except:

1. completing the consent for research for your patient.
2. initiating discharge planning during the admission assessment.
3. educating the patient regarding post-op care and expected post-op care needs.
4. maintaining the medical record as a confidential document.

(1) Completion of informed consent procedures and documentation is the right of the patient in order to maintain self-direction and autonomy. Discharge planning is expected in continuity of care. The confidentiality of medical records and patient information is also a right. Patient education will help to meet the patient's right to information regarding diagnosis, treatment, and prognosis.

**42.** When a patient is admitted to a psychiatric facility, the patient:

1. has the right to expect that his medical information will not be kept confidential.
2. has no right to decline to participate in research.
3. does not require informed consent prior to procedures.
4. has all of the same rights as other patients in acute care facilities.

(4) Patients admitted to psychiatric facilities have all of the same rights as other patients in acute care facilities.

**43.** You are working in the ER when an unconscious multiple trauma victim is admitted. You know that:

1. emergency surgery may be completed if deemed necessary by two attending physicians when a patient is unable to give consent and the next of kin cannot be reached.
2. you must wake the patient and obtain consent for surgery.
3. his girlfriend can give consent when his parents cannot be reached.
4. consent must be obtained from the next of kin, so the patient must wait for surgery.

(1) Standards of practice and many state laws support the initiation of emergency surgery if deemed necessary by two attending physicians when a patient is unable to give consent and the next of kin is unavailable to give consent.

**44.** Your patient suffered a stroke and is being cared for by the interdisciplinary stroke team. She has a right to expect considerate and respectful care from:

1. the nursing staff.
2. each member of the interdisciplinary team.
3. her family.
4. the nursing assistants.

(2) Each patient has the right to expect considerate and respectful care from all members of the healthcare team as well as all individuals working within the healthcare facility.

**45.** You meet your new nurse manager for the first time. She makes eye contact, smiles, initiates a conversation about your previous work experience, and encourages your active participation in the dialogue. Her behavior is an example of:

1. aggressiveness.
2. passive-aggressiveness.
3. passiveness.
4. assertiveness.

(4) As aggressive behavior dominates or embarrasses, passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness. This case exemplifies assertive behavior.

**46.** The power a nurse exerts when he/she works to accomplish goals and effect change in an agency or in policy is considered what type of power?

1. political
2. personal
3. positional
4. professional

(1) Political power results from one's ability to work within systems or agencies or through policy in order to effect change. Personal power is based upon one's charisma and self-confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based upon one's professional skills and abilities resulting from one's recognized expertise in an area of practice.

**47.** You belong to a professional nursing organization that provides social, educational, and political venues for nurses. You are active in the organization for almost two years, during which time you meet and work with nurses from several different nursing agencies and healthcare institutions in order to achieve a variety of goals, including obtaining advice regarding a personal career choice. This is an example of:

1. professional nurturing.
2. networking.
3. mentoring.
4. collegiality.

(2) Networking involves the process of developing and using contacts throughout one's professional career for information, advice, and support. Nurturing and mentoring are both examples of assistance to other colleagues in formal and informal relationships for support and career building. Collegiality is the professional camaraderie or rapport established among persons through shared experiences.



**48.** As a nurse on a 25-bed med-surg unit, you might expect your nurse manager to be involved in all of the following activities except:

1. evaluating nursing care given and ensuring appropriate documentation of such care.
2. providing clinical facilities and learning experiences for nursing students.
3. selecting laboratory personnel for hire.
4. providing for staff development and staff education.

(3) A nurse manager might appropriately select and hire nursing personnel but would not likely have the hiring authority for laboratory personnel. Nurse managers are responsible for all aspects of the nursing care on their units including documentation and do participate in providing education for their staff and for students.

**49.** The role of the clinical nurse specialist in the delivery of nursing care is:

1. consult with and collaborate with the interdisciplinary team to develop and implement a comprehensive plan of care for specific patients.
2. participate as the direct care delivery person for a select patient case load each day.
3. define the medical plan of care for specific patients.
4. act as a liaison for each patient with specific therapies during their hospital stay.

(1) The clinical nurse specialist works with complex patients in order to facilitate comprehensive plans of care by the interdisciplinary team. He/she is not regularly involved in direct patient care for only a select case load but is generally involved in the oversight of many patients; he/she might be involved in assisting with the medical plan of care but is not the sole definer of that care. Although the clinical nurse specialist might assist in discussions of therapy needs, the primary nurse for that patient would be responsible for the communication regarding specific therapy.

**50.** As a staff nurse, you participate on your unit's committee for quality care. The types of tools that you might use to evaluate nursing care include all of the following except:

1. nursing care audits.
2. nursing care outcome studies.
3. utilization review data.
4. performance appraisals.

(4) Performance appraisals are confidential forms between the manager and the employee and not available for open review. The results of nursing care audits, outcome studies, and aggregate data from utilization reviews are all appropriate sources of information for evaluating the delivery of nursing care.

**51.** Standards of practice for nursing:

1. define the highest level of nursing practice acceptable.
2. are utilized instead of nurse practice acts in states where there is no nurse practice act.
3. provide authoritative statements by which the quality of practice, service, or education might be evaluated.
4. are useful as guidelines only for the provision of care.

(3) Standards of practice do provide statements from which evaluations of the quality of practice, service, and education might be made. Standards of practice define the minimum level of practice and might take the form of specific protocols for care or general guidelines. Each state has a nurse practice act that regulates the practice of professional nursing in its state by law.

**52.** As a new nurse seeking employment, you must present to your potential employer with which of the following?

1. valid proof of residency
2. valid proof of malpractice insurance coverage
3. valid proof of nursing licensure
4. valid driver's license

(3) Proof of licensure as either a registered nurse or practical nurse is required prior to hire as a registered or practical nurse. Current residency, current driving privileges, and current malpractice insurance coverage are not required.

**53.** The basic legal requirement for employment as a nurse in any state is:

1. accreditation of the institution as an employer of nurses.
2. licensure of the nurse as a registered or practical nurse by that state.
3. certification of the nurse as a registered or practical nurse.
4. proof of malpractice insurance coverage of the employing healthcare agency.

(2) Licensure of the nurse as having met the requirements to practice nursing in that state is the basic minimum legal requirement to practice in that state. Malpractice insurance by the employing agency, certification for advanced practice, and agency accreditation to employ nurses are all not required in order to hire a nurse.

**54.** The scope of practice for a registered or practical nurse in a state is determined by:

1. professional standards of practice.
2. the state nurse practice act.
3. accreditation of the employing agency by nongovernmental organizations.
4. professional organization nursing certification.

(2) The nurse practice act of a state contains the legal definition of the scope of practice of the different levels of nursing within that state. Professional standards of practice are statements by which practice may be judged, which are delineated by professional nursing organizations. Although employing agencies define job responsibilities for certain job categories, the scope of practice for a nurse is defined by the state nurse practice act. Professional certification denotes meeting certain predetermined standards in specialty practice and is in addition to nursing licensure.

**55.** You are asked to assist in the evaluation of a nursing colleague with whom you practice. This type of evaluation may be termed:

1. peer review.
2. certification of practice patterns.
3. board of review.
4. accreditation of nursing practice.

(1) The peer review process involves professional review of work output and outcomes of colleagues at the same level or within the same job category. Each of the other evaluation mechanisms are not limited to the review of professional practice or necessarily utilized by professional nurses.

**56.** Legal protection of confidentiality:

1. extends only to written documentation.
2. extends to the electronic dissemination of information not identifiable to a specific patient.
3. is important only within the court system.
4. extends to both written and verbal information.

(4) Legal protection of confidentiality extends to both written and verbal information identifiable as individual private health information.

**57.** Confidentiality is a right of patients' that is supported by:

1. the American Hospital Association's "Patient's Bill of Rights."
2. the ANA "Code of Ethics."
3. HIPPA.
4. all of the above.

(4) Confidentiality is an ethical and legal right of the patient supported by the federal HIPPA legislation, the American Hospital Association's "Patient's Bill of Rights," and the American Nurses Association "Code of Ethics."

**58.** You are walking in the hallway of an acute care unit of the hospital in which you work when you realize you are overhearing the change of shift report. You should:

1. make the charge nurse on the unit aware of the situation so that she/he can take the necessary steps to maintain the confidentiality of the information being reported.
2. not worry about the information as it changes quickly on the acute care unit and will be outdated within two to three hours anyway.
3. mind your own business and return to your own unit as you would not want anyone to know you have overheard confidential information.
4. ignore the situation.

(1) In order to protect the confidentiality of the information being reported, you should make the charge nurse on the unit aware of the situation so that the information may be communicated in an appropriate way in privacy.

**59.** A legal right to confidentiality of patient information is waived when:

1. a court system subpoenas information.
2. a family member requests healthcare information of a patient.
3. a living will takes effect.
4. the patient is declared incompetent by the legal system.

(1) The legal right to confidentiality is waived when the court requires information to be given to the court in order for legal proceedings to occur (summonses, court orders, litigation information necessary for the court, subpoenas, and so on), when the state requires mandatory reporting of certain illnesses, when sharing of information is necessary as a patient has revealed an intent to harm himself or others, or if a patient cannot make a safe and rational decision (competence).

**60.** Your patient is a 27-year-old first-time mother who is giving her newborn up for adoption. Her family members have a right to what information?

1. the baby's sex
2. the name of the father of the baby
3. no information except that which is shared with them by the birth mother
4. a full medical chart review

(3) As a competent adult, the birth mother has the right to share or not share information regarding the birth and the child.

**61.** The legal requirement for the maintenance of confidentiality of patient information in healthcare extends to all of the following except:

1. physicians.
2. social workers.
3. physician's office receptionist.
4. the media.

(4) The legal requirement for the maintenance of confidentiality of patient information in healthcare legislated by HIPPA extends to all healthcare personnel (including the physician's office receptionist), but not to nonhealthcare personnel such as the media.

**62.** You find a medical record on the floor in the main hallway of the healthcare facility in which you work. You should:

1. open it and read it to find out to whom it belongs.
2. return the record to medical records unopened.
3. return the record to the nearby gift shop for them to take care of.
4. ask a nearby visitor to return the record to the lobby information desk.

(2) In this situation, in order to preserve the confidentiality of the information contained in a misplaced medical record, it should be returned to the medical record department unopened so that it may be correctly claimed by the person losing the record.

**63.** Confidential healthcare information is:

1. written information only.
2. verbal information only.
3. both written and verbal information.
4. found only in medical records.

(3) Confidential healthcare information is written, verbal, or electronic; it is found in a variety of sources including medical records, insurance records, demographic information, diagnostic test reporting, on computer systems, and in electronic transmittal systems such as fax transmissions, as well as other sources.

**64.** Healthcare information not covered by confidentiality legislation includes:

1. signed informed consent agreements.
2. information that identifies an individual.
3. information that could reasonably be believed to identify an individual.
4. information that could not reasonably be believed to identify an individual.

(4) The healthcare information that is protected information covered by HIPPA confidentiality regulations includes any information, including demographic information, that identifies an individual, or could reasonably be believed to identify an individual.

**65.** Disclosure of healthcare information might occur:

1. when permission is given by a competent patient.
2. under no circumstances.
3. when there is no risk to the safety of the public.
4. only after permission is granted by the court.

(1) Healthcare information may be disclosed when permission is given by a competent patient, when there is a risk of harm to self or others by a patient, when there is a threat of harm to the community (such as in communicable disease reporting), and when the courts request specific information.

**66.** Confidentiality is a legal right ensured by:

1. OBRA.
2. HIPPA.
3. Patient Self-Determination Act.
4. ANA's "Code of Ethics."

(2) Confidentiality is a legal right ensured by HIPPA. OBRA deals with nursing home regulation. The Patient Self-Determination Act is related to the right of choice of the patient. The ANA's "Code of Ethics" provides ethical standards for the practice of nursing.

**67.** As a nurse working in a free clinic, you realize that persons who are economically underprivileged are most likely to obtain healthcare from:

1. the primary care physician (family doctor).
2. neighborhood clinic.
3. specialists.
4. the emergency rooms/urgent care facilities.

(4) Statistical patterns of healthcare utilization indicate that the emergency rooms and urgent care facilities provide a large portion of healthcare to those with less economic or financial resources. This becomes problematic as routine care is often accessed in the higher cost healthcare sites.

**68.** As a nurse discharge planner preparing your patient for discharge from acute care, you assess that home care services are clinically indicated. Your assessment is based on all of the following indicators except:

1. your patient has been admitted to the hospital three times in the last two months.
2. your patient has a Foley catheter.
3. your patient's family will be there to care for him 24 hours/day.
4. your patient is ordered to continue IV antibiotics 5 days post discharge.

(3) 24-hour family availability to provide care and assistance is not an indicator for home care. In fact, the nurse might see some opportunity for family education in meeting the patient's needs so that less community support may be needed. This would need to be negotiated with the family. Frequent hospital readmissions imply that the patient has not been able to manage either due to condition instability or lack of care needs being met. This would be a red flag for home care services to be able to meet those needs and appropriately monitor the patient. A Foley catheter is an indication for home healthcare due to infection potential and care requirements. IV antibiotics involve home care due to maintaining line patency and assessment of the site.

**69.** Your patient has experienced a CVA with right hemiparesis and is ready for discharge from the hospital to a long-term care facility for rehab. To provide optimal continuity of care, the nurse should do all of the following except:

1. document current functional status.
2. have the physician phone report to the receiving facility.
3. copy appropriate parts of the medical record for transport to the receiving facility.
4. phone report to the facility.

(2) It is the nurse's responsibility to communicate the patient's condition and care plan to the receiving facility in order to support continuity of care. Documentation of the patient's baseline functional is important for the receiving facility to work with in further goal setting. A copy of select portions according to facility policy is another form of communication and will support continuity. A physician may be asked to be involved if there are specific medical needs or orders that he/she believes are important but is generally not involved.

**70.** An older adult man is being discharged from the hospital with lung cancer. He will be going to live with his daughter and her family. To promote continuity of care, the nurse should:

1. explore community service options with the patient and his family.
2. make a referral to hospice.
3. convince the family that a nursing home placement may be better.
4. support the family's decision and help him leave the hospital.

(1) The nurse should explore the support service options with the patient and family so that they can be aware of and obtain support as needed. Further assessment is needed before the hospice referral; it may be premature. It is never appropriate for the nurse to impose his/her opinions about what's best for the patient. A more educational approach needs to be taken presenting options so that the patient and family can make their best decisions.

**71.** A client who receives care at least in an overnight stay in a hospital or other healthcare facility is considered an inpatient. An implication for care is:

1. reimbursement at the same rate as outpatient care.
2. potentially delayed access to continuum of care services (for example, skilled nursing facility or home care services).
3. medical problems will be resolved upon discharge.
4. discharge planning services will assist in links to outpatient services as needed.

(4) Hospital discharge planners have a professional responsibility upon a patient's discharge to link the patient with necessary services. Reimbursement rates are generally higher in acute care compared to outpatient care. Medical problem resolution is generally completed after hospital discharge at home, with community-based support services or other facility-based care.

**72.** As a nurse, you identify that your diabetic patient has misunderstandings about her prescribed diet. For follow-up upon discharge, you refer her to:

1. an endocrinologist.
2. a physician's assistant.
3. dietician.
4. cooking classes.

(3) A patient who has misunderstandings about healthcare strategies needs further education. A major part of the dietician role is nutritional counseling and follow-up, which would be most appropriate in this scenario. An endocrinologist is a physician who specializes in diabetes; their focus is on the medical care aspects. A physician's assistant may be an educational support but does not have the background or expertise in nutrition. Cooking classes offer meal strategies but would not provide the educational support needed to clarify this patient's understanding.

**73.** The nurse is preparing a hospital discharge to home for a patient who has had a total knee replacement. Therapy is indicated to support the patient's recovery. The nurse understands that in order to have therapy services initiated, an order:

1. is not required for reimbursement.
2. may be written by discharge planner.
3. may be written by the therapists themselves.
4. requires a diagnosis to focus the therapist goals for treatment.

(4) An order for therapy must include direction for the need for therapy along with supportive diagnoses. An order is required for reimbursement as that helps to justify the need for therapy services. The order must be written by a physician or physician extender (NP) according to practice laws of the state. It may not be written by a nurse or social worker discharge planner or the therapists themselves.

**74.** Potential sites for breakdown of continuity of care are:

1. intra-unit transfers in an acute care setting.
2. hospital discharge to home care services.
3. nursing change-of-shift report.
4. all of the above.

(4) A potential for breakdown of continuity of care exists any time there is a change in caregiver or change in location. Thorough, concise communication is required to maximize a patient's opportunity to reach desired outcomes at all times.

**75.** Functionally impaired adults might receive care that is provided onsite in all of the following care settings except:

1. long-term care.
2. adult day care.
3. independent apartments.
4. home with 24-hour caregiver.

(3) Functional support services (that is, therapies according to reimbursement) are usually not available in independent living sites. Most insurance (Medicare included) requires that an individual be considered home bound to qualify for in home services. People who are independent, even for short-term rehab generally are required to go to a therapy site of service.

**76.** A daytime community-based program for adults with functional and cognitive problems that provides individualized care is:

1. hospice.
2. home care.
3. adult day care.
4. respite care.

(3) Adult day care services provide a variety of services to community based adults, in particular older adults. Most people who use adult day services are cognitively impaired and/or have varying degrees of physical frailty. These programs help delay institutionalization for those who need some supervision but do not need continuous care. This allows family members/caregivers to maintain their lifestyles and employment and still keep their loved one at home. Hospice services provide end-of-life services in a variety of settings but do not offer daytime supervision. Respite care services provide short-term relief or time off for caregivers of ill, disabled, or frail older adults.

**77.** As a nurse discharge planner explaining available outpatient services to a family contemplating discharge, you explain that rehab or skilled care:

1. is focused on short-term functional outcomes.
2. deals with chronic decline in health status due to chronic illness.
3. maintains cognitive function.
4. includes respite care.

(1) Skilled or rehab services are generally short-term, goal-directed services geared toward specific functional outcomes. They do not encompass long-term chronic health issues. The majority of skilled services are physical in terms of therapy (that is, physical therapy, occupational therapy, and/or speech therapy). Respite services are not included as a component of skilled care.

**78.** Quality is defined as the cumulative combination of all of the following except:

1. conforming to standards.
2. performing at the minimally acceptable lower level.
3. meeting or exceeding customer requirements.
4. quality so good that efforts have significantly exceeded customer expectations.

(2) Minimal compliance or performance at the minimally acceptable level is not considered to be quality.

**79.** As a type of quality indicator, an example of a structure standard is:

1. a written philosophy.
2. a procedure for a straight catheterization.
3. a protocol for treatment of a patient with chest pain.
4. the diagnostic work-up for a patient with abdominal pain.

(1) Structure standards define all the conditions needed to operate, direct, and control a system. They do not address patient care but rather describe structure with regard to purpose; such as philosophy, objectives, goals, hours of operation, and management responsibility.

**80.** An example of a process standard on a med-surg unit is:

1. a procedure for changing IV tubing.
2. a policy for staffing.
3. the job description of the CEO (chief executive officer).
4. a procedure for checking waveforms on a patient being treated on an intra-aortic balloon pump.

(1) Process standards define the actions and behaviors required by staff to provide care. A procedure for changing IV tubing is a psychomotor skill that is applied to helping the patient meet their goals.

**81.** An example of an outcome standard in a rehab area is:

1. physical therapy involvement for all patients.
2. serving meals at consistent times so that other activities may be planned.
3. patients will achieve maximum functional ability including ambulation and transfer status post hip fracture repair.
4. a procedure for the use of a passive range of motion machine (PROM).

(3) Outcome standards indicate the change in the patient's condition following treatment. A procedure is a process standard.

**82.** Which of the following is a correctly stated threshold for evaluation in the continuous quality improvement process?

1. Diabetic patients are able to discuss their prescribed individualized meal plans.
2. Most of the patients following hip surgery will be able to ambulate with crutches.
3. 85 percent of the patients will verbalize satisfaction with the responsiveness of staff to their call light.
4. Most of the patients following hip surgery will maintain normal lung function with no evidence of pneumonia.

(3) A threshold is a quantitative measure (usually expressed as a percentage) that is used to define whether or not a problem exists.

**83.** The responsibility for defining the process, setting goals, monitoring activities and evaluating nursing care in a unit-based quality improvement program is assigned to:

1. the hospital administration.
2. the Director of Continuous Quality Improvement (CQI).
3. the professional staff nurses working on the unit.
4. the Director of Nursing.

(3) In a unit-based program, the responsibility for the program is decentralized to the professional staff nurses working on the unit.

**84.** "Patients receiving antibiotics through a central IV line will not experience infection" is an example of:

1. a structure indicator.
2. a process indicator.
3. a process goal.
4. an outcome indicator.

(4) An outcome indicator defines the intended result of a medical and/or nursing intervention.



**85.** The overall goal of a Continuous Quality Improvement (CQI) program is to:

1. ensure that patients receive quality care.
2. document nursing errors for performance monitoring.
3. protection from liability.
4. identify ways to improve healthcare.

(4) Quality of care is a dynamic and individualized concept in many cases. Continuous quality improvement programs are designed to make improvements in whatever the level of current “quality” provided is within an organization.

**86.** It is less challenging for nursing than other healthcare disciplines to embrace/work with the Continuous Quality Improvement (CQI) process because:

1. nurses are patient advocates.
2. the process is similar to the nursing process.
3. nurses like to do things right.
4. nurses take pride in their profession.

(2) The CQI process is similar to nursing process in that they are both problem-solving methods.

**87.** JCAHO’s 10-step process for quality improvement and the Focus-PDCA model are two models commonly adopted for the organization of Continuous Quality Improvement programs. Similarities between these models include all of the following except:

1. they use a systematic approach ensuring that participants are on common ground in their efforts.
2. they generate unique findings based on the process used.
3. they are cyclical.
4. they identify a process or problem.

(2) The models used for Continuous Quality Improvement assist the development of an organized program using a systematic approach. They offer a structured means of problem identification and resolution that can be repeated over time according to need. The findings and problem solving that results is similar; although the steps of the process may have some differences.

**88.** Measuring patient satisfaction as a focus of Continuous Quality Improvement (CQI) is beneficial in that the results provide useful outcome measures for quality. Satisfaction reflects:

1. reduced risk of malpractice.
2. reduced hospitalization
3. reduced length of stay
4. patient perceptions of quality of care.

(4) Reduced risk of malpractice and reduced hospitalization and length of stay are benefits of the patient’s perceptions of quality of care, which is expressed in terms of satisfaction.

**89.** Your 65-year-old female patient is having post-menopausal bleeding. You encourage her to see a physician of what type?

1. radiologist
2. gynecologist
3. psychiatrist
4. oncologist

(2) A gynecologist is the physician who treats and manages disease of the female reproductive organs. A radiologist evaluates x-rays; a psychiatrist is the physician manager of the rehabilitation team; an oncologist treats patients with cancer.

**90.** In the process of an annual physical exam, your father is diagnosed with benign prostatic hypertrophy (BPH). You may expect that he will have a consult to see which physician?

1. gynecologist
2. physiatrist
3. urologist
4. proctologist

(3) A urologist is the physician who specializes in urinary tract and prostate disease. A gynecologist specializes in disease of the female reproductive tract; a physiatrist specializes in rehabilitation care; a proctologist specializes in lower colonic digestive diseases.

**91.** A gastroenterologist would be consulted for patients suffering from:

1. digestive system diseases.
2. urinary system diseases.
3. female reproductive system diseases.
4. nervous system diseases.

(1) A gastroenterologist cares for patients with digestive system diseases. A urologist cares for patients with urinary system diseases; a gynecologist care for patients with female reproductive system diseases; a neurologist cares for patients with nervous system diseases.

**92.** The physiatrist at the skilled nursing facility:

1. cares for patients with wound care needs.
2. cares for patients with digestive diseases.
3. dares for patients with rehabilitation needs.
4. cares for patients with surgical needs.

(3) A physiatrist cares for patients with rehabilitation needs, such as a CVA or multiple trauma patients.

**93.** A patient you are caring for in home care has just lost her son. An appropriate consult for her at this time may be:

1. a minister or chaplain.
2. a psychologist.
3. a bereavement counselor.
4. any of the above.

(4) Bereavement counseling may be done by ministers or chaplains of a religious faith, by psychologists or by counselors trained in bereavement counseling.

**94.** You have a patient with rheumatoid arthritis who is starting a new medication treatment. This is likely managed by:

1. a pulmonologist.
2. an orthopedic surgeon.
3. a rheumatologist.
4. a physical therapist.

(3) A rheumatologist is the physician specialist who manages the medical treatment of diseases involving the bones, joints, and connective tissues (such as rheumatoid arthritis). A pulmonologist specializes in caring for patients with respiratory disease; an orthopedic surgeon specializes in surgical treatment of bones and joint diseases; and a physical therapist specializes in working with patients with mobility and balance disorders at the direction of a physician.

**95.** Your patient has had hip surgery and is now ready for therapy. You would expect their primary therapy to be:

1. physical therapy.
2. nutrition therapy.
3. occupational therapy.
4. speech therapy.

(1) Physical therapy for restoration of mobility, gait, and balance would be the primary therapy consulted after hip surgery. The other therapies would not be necessary as direct consultants.

**96.** Your patient suffered a second-degree burn to the right hand and forearm and is now ready for therapy. You would expect the primary therapy to be:

1. physical therapy.
2. speech therapy.
3. occupational therapy.
4. pulmonary rehabilitation.

(3) The primary therapy modality for an upper extremity burn would be occupational therapy in order to restore function and as much dexterity as possible of the extremity. Physical therapy deals with mobility, gait, and balance; speech therapy deals with speech, swallowing, and cognitive functioning; pulmonary rehabilitation deals with maximizing function in patients with respiratory diseases.

**97.** Your patient with schizophrenia would most likely be treated by which consultant?

1. physiatrist
2. psychologist
3. psychiatrist
4. social worker

(3) Persons with mental illnesses such as schizophrenia are treated by psychiatrists in order to combine psychiatric counseling and medications in the treatment plan. A physiatrist treats rehabilitation patients; a psychologist treats patients with counseling and support; a social worker might assist patients with the planning of support, obtaining material resources, or short-term counseling.

**98.** Your patient has a consult for a podiatrist. You would expect this consultant to:

1. care for your patient's hands.
2. care for your patient's hearing.
3. care for your patient's feet.
4. care for your patient's eyes.

(3) A podiatrist is a specialist in foot care.

**99.** An audiologist would be consulted for:

1. diminished hearing.
2. diminished vision.
3. retinal damage.
4. aphasia.

(1) An audiologist is a specialist in hearing abnormalities and hearing aides. An ophthalmologist cares for patients with retinal damage; an optometrist cares for patients with decreased vision; a speech therapist treats patients with aphasia.

**100.** All of the following are common reasons that nurses are reluctant to delegate except:

1. lack of self confidence.
2. desire to maintain authority.
3. confidence in subordinates.
4. getting trapped in the “I can do it better myself” mindset.

(3) If a delegator has confidence in their subordinates that the task will be done correctly, they will be more likely to delegate. Reasons that delegators are reluctant to delegate include their own lack of confidence, fear of losing authority or personal satisfaction, feeling that they need to do it themselves in addition to having difficulty letting go.

*Scenario: Questions 101–102*

Jack Stone, a 16 year old was in a bicycle accident earlier today and was hospitalized for a concussion and a compound fracture of his right humerus. He was taken to surgery for repair of the fracture and is 11 hours post-op now on the unit to which you are assigned. His right arm is casted. He is to be observed for possible internal injuries in addition to ongoing neural assessment. Vital signs are every hour. He has been ordered clear liquids as tolerated and has a maintenance IV at 75 ccs per hour until tolerating fluids. You are working with an LPN and nursing assistant.

**101.** All of the following tasks may be delegated to the LPN except:

1. the patient’s admission assessment.
2. every 2-hour circulation checks of the right hand distal to the cast.
3. performing a straight catheterization if he is unable to void.
4. monitoring the vital signs.

(1) The patient’s admission assessment is an RN responsibility. Performing a straight catheterization procedure, circulation checks, and vital sign monitoring are skills within the LPN’s scope of practice.

**102.** In making the decision to delegate care of this patient to the LPN, what is the priority consideration that the RN needs to make?

1. the LPN’s skill level
2. the LPN’s experience level—is their familiarity/competence with the skills required?
3. the stability of the patient’s status
4. the number of patients within each assignment

(3) The patient’s stability would be a first consideration. If he were unstable, it would be appropriate that the RN be more directly involved in monitoring the aspects of care as part of an ongoing assessment.

**103.** All of the following tasks could be delegated to a nursing assistant or unlicensed assisting personnel (UAP) except:

1. performing the catheterization.
2. assisting the patient to the bathroom.
3. offering fluid intake every 1–2 hours.
4. monitoring/recording the amount of fluid taken.

(1) A urinary catheterization is a sterile procedure that must be completed by an RN or LPN. Assisting during activity, offering fluids, and recording intake are in the job scope of the nursing assistant.

*Scenario: Questions 104–105*

Mrs. B has type 2 diabetes, which has been fairly stable until the last 2 weeks. She is now experiencing blood sugars greater than 200. She has a diagnosis of cellulites of the left foot with dressings to be changed every 2 hours. Her vital signs are stable, and she feeds herself. She is taking a vicodin every 4 hours for pain, which gives her some short-term relief.

**104.** All of the following tasks may be delegated to the LPN except:

1. developing a patient teaching plan regarding the patient's diet, exercise, and medications.
2. monitoring Mrs. B's blood sugars via accucheck.
3. performing dressing changes to the infected foot.
4. administering the patient's pain medication.

**(1)** Developing a patient teaching plan is a professional nursing function that is in the scope of RN responsibilities. RNs may delegate specific teaching activities to an LPN in order to execute the plan using the same five rights of delegation. Accuchecks, dressing changes, and medication administration are tasks within the role of the LPN (in most states).

**105.** On the third day during which you are caring for Mrs. B., she complains of chills. Checking her temperature, the nursing assistant comes to you, and reports that it is 101.8.

As you assess Mrs. B., you discover that her wound looks more inflamed, feels hot to touch, and is oozing some yellow/green drainage. The patient tells you that it's been like that the last two days. Checking the chart, you see that the LPN who had done the dressing changes documented a similar appearance two days ago. Who is responsible?

1. the nursing assistant who checked her temperature
2. the LPN who did the dressing changes
3. you are, as the RN
4. you, as the RN, and the LPN

**(4)** Both the RN and the LPN are responsible in this situation. The LPN who performed the dressing changes did not recognize signs of infection, and/or if she did she failed to bring them to the attention of the RN. As the RN, you are also responsible for the care that you delegated to this LPN. The RN retains responsibility for tasks that are delegated and must perform necessary supervision.

**106.** Which direction given to the nursing assistant is most likely to accomplish the task of getting a urine specimen delivered to the lab immediately after collection?

1. "Make it a stat delivery."
2. "Please do it as soon as you can after break."
3. "This patient is delirious, and we're worried about a urinary sepsis."
4. "Take this patient to the bathroom now and collect a urine specimen from this voiding. Take the specimen to the lab immediately."

**(4)** Effective delegation depends on clear, concise direction that leaves no room for question or interpretation on the part of the one being delegated to. Nursing assistants have a limited understanding of medical conditions and terminology and should not be relied on to prioritize accordingly.

**107.** In communicating a delegated task to a nursing assistant (UAP), an example of optimal direction is:

1. "Let me know if you see any signs of a heart attack."
2. "Please offer the patient the bedpan every two hours on the even hours. Let me know the total urine output at 2:00 P.M."
3. "Let me know whether anything happens with this confused patient."
4. "Keep an eye on this hallway while I'm at lunch."

(2) When delegating, the use of specific, behavioral direction will be most likely to obtain desired results.

**108.** Decisions regarding which tasks may be delegated by the RN are made by:

1. the American Medical Association (AMA).
2. JCAHO.
3. each State Board of Nursing.
4. the ANA.

(3) The definition of the scope of nursing practice is the responsibility of each state board of nursing.

**109.** Who has the responsibility for ensuring that nursing staff at all levels have the appropriate competencies in order to safely function in their job description?

1. the ANA
2. the State Boards of Nursing
3. the agency or institution of employment
4. the RN in charge

(3) Each agency or institution of employment has the responsibility of ensuring that staff have appropriate competencies as guided by the state practice acts. This is accomplished through the process of orientation, ongoing staff development, and management practices of supervision and quality assurance.

**110.** The manager making the delegation is the:

1. delegee.
2. delegator.
3. supervisor.
4. delegate.

(2) The person responsible for delegating is the delegator. The delegate is the person receiving the delegated task. The supervisor is the person who provides guidance for the accomplishment of a task or activity. Delegee is an incorrect term.

**111.** Mrs. T is an 80-year-old client admitted to your nursing unit with a diagnosis of weakness, status post fall. The admission face sheet indicates that she is widowed and lives alone. As you work through your nursing admission assessment, which of the following would be the least priority concern?

1. Ask Mrs. T about the details of her fall.
2. Does Mrs. T like to read?
3. Ask Mrs. T about her ability to shop and cook for herself.
4. What medications has she been taking?

(2) Mrs. T's reason for admission is weakness and a fall. Priority concerns in assessment would be to identify any intrinsic or extrinsic factors that lead to her fall. Her interest in reading, although it be important in determining possible activities to incorporate into her care plan while in the hospital, is a lesser priority.

**112.** You are caring for several patients on a busy step-down unit. You are changing a patient's sacral decubitus dressing when an nursing assistant comes to tell you that the pharmacy has just delivered the lasix to be given IV for another patient experiencing dyspnea secondary to CHF. What is the most appropriate action?

1. Ask the nurse aide to find someone else to give the lasix.
2. Slap on a piece of the old dressing on the patient with whom you're currently working and go and give the lasix.
3. Quickly cleanse the decubitus per procedure; apply wet-dry packing as ordered, and ask the nursing assistant to tape down the edges.
4. Finish the dressing, redress the patient, and ambulate to the bathroom per patient's request. When finished with this patient, go and check on the lasix and the other patient.

(3) The appropriate priority in this situation is to finish the immediate task in an adequate manner, and then quickly move to the care of the patient who is symptomatic needing intervention. To ask the nurse's aid to find someone else would involve a time delay; perhaps take even more time in responding to the patient as another nurse would need to stop and assess to understand the situation in order to intervene appropriately. Completing care on the current patient including assisting with toileting is not appropriate and could be putting the patient with dyspnea symptoms at risk.

**113.** Following change of shift report, you analyze your information and set priorities according. When a plan has been determined, at what point during the shift can or should your plan be altered or modified?

1. halfway through the shift
2. at the end of the shift before reporting off
3. at any given moment
4. after your "top priority" tasks have been completed

(3) After priorities are established, as a nurse you need to realize that they might change at any given point in time.

**114.** All of the following factors may influence a nurse's change of priorities except:

1. a change in patient status.
2. a physician making rounds who writes new orders.
3. a family member with concerns and questions.
4. a personal call about after work activities.

(4) There are a multitude of factors that could influence priority setting at any given moment. using good time management principles. Factors to be acknowledged should be patient care centered only.

**115.** The nurse uses priorities to determine all of the following except:

1. time allotment for certain tasks.
2. appropriate interventions.
3. treatment procedures.
4. the need for patient education.

(3) Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure in order to be compliant with practice standards. Established priorities will contribute to the determination of time management, appropriate interventions, and the need for patient education as a potential intervention.

**116.** Priorities to be considered "intermediate" are:

1. the nonemergency, nonlife-threatening needs of the patient.
2. those tasks that can be delegated to assistive personnel.
3. those tasks that can be done at the end of the shift.
4. those task that can be done at any time.

(1) Priorities designated as “intermediate” by the nurse are those that are nonurgent. They do not affect the patient’s immediate physiological status. That does not imply that they are not important or not necessary. Intermediate priorities may still require the skill level of the RN for completion. There may be specific time requirement for completion as well.

**117.** Of the tasks listed, which would be considered an intermediate priority?

1. a patient post-extubation that O<sub>2</sub> stats are ranging from 83–88 percent
2. a post-op patient with a colon resection whose wound dehiscd
3. an elderly patient with chronic diarrhea for three weeks
4. a patient that pulled out her central line and is bleeding

(3) The elderly patient with chronic diarrhea for three weeks would be categorized an intermediate priority in the context of the other answer choices. The diarrhea needs to be addressed as it is a significant problem with potential risks and negative consequences; however, the other situations would command high-priority attention.

**118.** An 85-year-old female resident (Mrs. A) who has Alzheimer’s disease is extremely upset because she can’t find her clothes. She comes to the nurse’s station in tears, hyperventilating and shaking. You are in the midst of assessing and treating another resident (Mr. B) with COPD, who is having breathing problems, and you are in the process of setting up oxygen therapy ordered and a nebulizer treatment with albuterol. What becomes your immediate top priority?

1. Stay focused on treating Mr. B.
2. Set aside the respiratory treatments and go and help Mrs. A find her clothes.
3. Explain to Mrs. A that her clothes are not missing.
4. Ask a nursing assistant passing by in the hallway to assist Mrs. A and focus on the treatments ordered for Mr. B.

(4) Your nursing priority in this case should be dealing with Mr. B who is physiologically unstable. However, Mrs. B’s psychological distress should not be considered less important. Delegating the task of providing assistance to Mrs. A to the nursing assistant will help to meet her immediate needs for attention and buy some time for you to address Mr. B’s problem.

**119.** A low-priority patient concern:

1. is one that is optional to address.
2. is the priority problem for the patient, not the nurse.
3. needs that may not be related to a specific illness or problem being treated.
4. is one that is not important in the overall quality of patient care.

(3) The nurse has an obligation to assist a patient in meeting their needs. Low-priority concern may still be significant in the overall picture and deserve the nurse’s attention at some point.

**120.** An important aspect to consider when dealing with a low-priority concern is:

1. the patient’s agreement that it is a low priority as well.
2. cost-benefit.
3. available resources.
4. all of the above.

(4) All aspects should be considered in dealing with a patient’s concern that is considered a low priority.



**121.** The nursing diagnosis “risk for infection” related to a 50-pack-per-year history of smoking would be considered:

1. a low priority.
2. an intermediate priority.
3. a high priority.
4. priority decision depends on the care setting.

(1) This would be considered a low priority as it reflects the client’s long-term health needs.

**122.** According to the ANA Code for Nursing, professional nurses have an ethical obligation to:

1. clients (patients).
2. profession of nursing.
3. provide high quality care.
4. all of the above.

(4) Quality of care, professional standards, and patient-centered care are all elements of the ANA Ethical Code for Nurses.

**123.** The ethical principle of keeping professional promises or obligations is:

1. veracity.
2. autonomy.
3. fidelity.
4. beneficence.

(3) The ethical principle of veracity is truth telling. Autonomy is patient self-determination (that is, patients making their own decision). Beneficence is the principle of “doing good,” which is a foundation of nursing care.

**124.** Issues addressed in ethics committees include all of the following except:

1. nonpayment of bills.
2. euthanasia.
3. starting or stopping treatment.
4. use of feeding tubes.

(1) Ethics committees do not deal with financial matters of payment. Euthanasia, stating or stopping treatment, and the use of feeding tubes to maintain nutritional status are topics within the ethical scope of the committee’s function.

**125.** The ethical principle of nonmaleficence is:

1. doing good.
2. freedom of choice.
3. do no harm.
4. truth telling.

(3) Nonmaleficence is the ethical principle of “doing no harm,” which the main concept of medicine’s Hippocratic Oath. The ethical principle of beneficence is “doing good.” Freedom of choice is patient autonomy. Veracity is truth telling.

**126.** The purpose of ethics committees is to:

1. have legal authority.
2. satisfy JCAHO requirement of all hospitals.
3. provide education and guide policy making regarding clinical issues.
4. provide healthcare personnel with legal protection from lawsuits.

(3) Ethics committees are formed in order to provide a resource to patients, families, and staff. They are not a requirement of JCAHO; many small hospitals do not have them. Committee work/decisions are presented as recommendations and are not considered “law.” Their purpose does not include determination of innocence versus guilt; thus, their action does not imply legal protection.

**127.** An ethical dilemma is one in which:

1. there is a clear-cut treatment decision.
2. there is no duty to provide care or treatment.
3. a problem exists in decision making because there is no right or wrong choice.
4. all involved parties agree on actions to be taken.

(3) An ethical dilemma is one in which there is no clear-cut treatment decision or there is disagreement about the course of action to take. There is usually a clear duty to provide care, but the type of care is under contention.

**128.** Withdrawal of medical care includes:

1. withdrawal of comfort care.
2. withdrawal of nursing care.
3. withdrawal of socialization.
4. withdrawal of curative treatment.

(4) Cure is no longer a goal of therapy when the decision has been made to withdraw treatment. A discussion of potential outcomes will have been part of the discussion leading to the decision of withdrawing care. Choices 1, 2, and 3 are incorrect. Nursing care, socialization, and comfort continue to be mechanisms to provide quality end-of-life care.

**129.** Nursing qualities described in ANA code of ethics include all of the following except:

1. maintenance of competence.
2. providing care with respect for privacy and dignity.
3. collaborating with colleagues to meet public health need.
4. care for patients without professional boundaries.

(4) The code of ethics supports all of these aspects of professional nursing and delineates the practice of nursing within the profession.

**130.** Types of patient care scenarios in which ethical dilemmas arise include all of the following except:

1. technology versus cost.
2. withholding food and fluids.
3. private room versus patient’s preference.
4. right to die at home versus remaining in the hospital.

(3) Ethical dilemmas occur when there is conflict resulting in two conflicting choices that have major consequences. A private room for convenience does not meet this definition.

**131.** The term *ethics* has no simple definition but encompasses:

1. human relationships with others.
2. establishing norms/standards for conduct.
3. moral judgment.
4. all of the above.

(4) The definition of ethics includes all of these elements.

**132.** At the end of the shift, you and a co-worker ride down the elevator discussing your challenging shift's events. Which of the following ethical principles did you both breach?

1. HIPPA
2. confidentiality
3. fidelity
4. beneficence

(2) Confidentiality is a patient right that nurses are bound to honor according to ethical codes. HIPPA is a law that mandates protection of personal information. Fidelity is the ethical principle of keeping promises. Beneficence is the ethical principle to do good for others.

**133.** A patient with massive chest and head injuries is admitted to the ICU from the ER. You know that all of the following are true except:

1. a declaration of wishes or documentation of wishes regarding organ donation by the donor is not necessary for organ harvesting.
2. the physician in charge of the case is the only person allowed to decide whether organ donation will occur.
3. only the patient's legally responsible party may make the decision for organ donation for the donor if the patient is unable to do so.
4. the organ procurement organization is involved in the decision regarding which organs to harvest.

(2) The donor or legally responsible party for the donor, the physician, and the organ procurement organization are all involved in the decision regarding whether organ donation is appropriate for a specific donor.

**134.** Because I carry a donor card for organ donation, I know that:

1. my medical care will be altered if I have serious injuries in order to get my organs for donation.
2. my family and legally responsible party will have no decision-making authority in the event that I am considered as an organ donor.
3. I am allowed to revoke my decision for organ donation at any time.
4. I will be considered as an organ donor for only one organ or tissue.

(3) Revocation of the decision for organ donation may occur at any time, by either the patient or responsible party. When organ donation is considered, as many organs as the donor wished to donate are considered and accepted for donation if found appropriate. Medical care for an individual during immediate care and/or resuscitation are not altered in order to declare a patient dead and ready for organ donation.

**135.** You are the ICU nurse caring for a patient who has just been declared brain dead. You know that one place you might find evidence of the patient's wishes regarding organ donation is:

1. on the driver's license of the patient.
2. in the patient's safety deposit box.
3. in the patient's last will and testament.
4. on the patient's insurance company card.

(1) In most states, indication of organ donor status is found on the driver's license. Evidence in a last will and testament or in a safety deposit box would not be readily accessible for decision making if the need arose. Insurance company cards do not contain such information. Another source might be the patient's primary care physician's health record documentation.

**136.** Transplantation of organs occurs:

1. between donor and recipient of the same sex only.
2. 24 hours a day, 7 days a week.
3. with the consent of the physician only.
4. only in the United States and Canada.

(2) Donors and recipients are not matched for age, sex, or race. All donations must be with the consent of the donor and/or the legally responsible party for the donor. Transplantation is done all over the world, 24 hours a day, 7 days a week, whenever organs are available.

**137.** Transplantation of organs in the United States:

1. is commonly done as a means to make money for a donor.
2. is organized for single tissue donation only.
3. is not accepted by most adult Americans.
4. is organized into a national waiting list with state affiliates acting as area organ procurement organizations.

(4) Organ donation in the United States is nationally organized with state affiliates acting as the organ procurement organizations in their respective areas. Organ donation in the United States is not done for monetary gain and includes both organ and tissue donations. More than 85 percent of adult Americans approve of organ donation.

**138.** Organ and tissue donation currently includes in the United States:

1. tissue donation of eyes, skin, and heart valves only.
2. donation of bone marrow between donor and recipient only.
3. organ donation of intestines, stomach, liver, and pancreas.
4. organ donation of heart, lungs, pancreas, liver, kidney, and intestines.

(4) Organs that may be transplanted include heart, kidney, pancreas, lungs, liver, and intestines. Tissues that may be transplanted include cornea, skin, bone marrow, heart valves, and connective tissue.

**139.** The role of the nurse in the care of a potential organ donor involves all of the following except:

1. resuscitation of patients who have expressed the desire of organ donation should the situation arise.
2. facilitating decision making in families and responsible parties of potential donors.
3. focusing the goals of care to encourage recipient-donor communication.
4. assistance in coordinating educational and counseling efforts for potential donor families.

(3) Communication among donors and/or their families and responsible parties with recipients of organ donation is not encouraged in order to protect the privacy and confidentiality of the donor. Potential donors who have organs for donation must be resuscitated in the event of death in order to procure viable organs for donation. Education, facilitation of decision making, and provision of counseling are all appropriate interventions for the nurse.

**140.** As a nurse working in home care with kidney failure patients, you know:

1. fourteen persons die each day waiting for an organ transplant.
2. more than two-thirds of the persons awaiting organ transplantation in the United States await liver transplants.
3. one in four persons awaiting a kidney transplant will receive the needed organ.
4. in 2003, more than 100,000 organ donations occurred in the United States.

(3) Only one-fourth of the almost 60,000 persons awaiting kidney transplants in 2004 will receive the needed organ donation, and two-thirds of those awaiting transplants are awaiting kidneys. Seventeen persons die daily awaiting transplants. In 2003, only 25,460 individuals received organ donations nationally.

**141.** A 77-year-old man suffers a traumatic CVA and is determined to be brain dead. He is currently on life support, and the physicians are preparing to talk with his wife and family about their findings. As the patient's nurse, you:

1. follow your agency protocol for notifying the organ procurement organization, which is mandated by federal law.
2. call the counselor or chaplain to be with the team when the physicians talk with the family.
3. make sure that all current documentation of the patient's status is on the chart for the organ procurement representative to evaluate when needed.
4. all of the above.

(4) The nurse is the first link in notification of the organ procurement organization for mandatory reporting by federal law. All result reporting and appropriate documents should be available to the organ procurement representatives for their timely evaluation. Support of the family at the time of the discussion of death is important in helping to answer questions and support of the grieving process.

**142.** You are caring for a 78-year-old Chinese man with heart disease who desires to be an organ donor. He is not a U.S. citizen, but has completed organ donation documentation, and his family is supportive of his decision. He suffers a massive myocardial infarction and requires resuscitation but does not recover. You know that all of the following are true except:

1. organ donation is possible after resuscitation if the resuscitation efforts are continued until harvesting of the organs can occur.
2. nonresident aliens may donate and receive organs in the United States.
3. up to 5 percent of the organs transplanted in a transplant center may be from other countries.
4. donation of organs by non-resident aliens will be for other nonresident alien recipients only.

(4) In a resuscitation effort, organ donation is possible as long as the organs are maintained as viable until harvesting. Non-resident aliens may be organ donors in the United States, and their organs may be used according to medical need and not only for other non-resident aliens. The policies of the Organ Procurement and Transplantation Network, which oversees international organ donation and transplantation, allow up to 5 percent of the recipients at a transplant center to be from other countries.

**143.** You are caring for a multiple trauma victim in the ICU who has just been evaluated as brain dead. You know:

1. most religions approve of organ donation as an act of charity.
2. the age of the donor will determine whether organs may be donated or not.
3. organ donation will disfigure the body and alter funeral arrangements such as arrangements for an open casket funeral.
4. many religions prohibit organ donation.

(1) Most religions do not prohibit organ donation, and view it as an act of compassion and charity. Age is not a determinant of organ donation ability. Organ donation does not disfigure the body for viewing at the funeral.

**144.** The following individuals may legally give informed consent:

1. Mr. C, an 86 year old with advanced Alzheimer's disease.
2. a 14-year-old girl, who is *not* an emancipated minor, needing an appendectomy.
3. a 72-year-old female scheduled for a heart transplant.
4. a 6-month-old baby needing bowel surgery.

(3) The 72 year old scheduled for heart transplant surgery may give informed consent for the surgery. There are no age limitations with the exception of minors. An individual with advanced Alzheimer's disease is incompetent to make decisions. Only an emancipated minor may give consent (a 14 year old who lives alone away from family and is totally independent).

**145.** Which of the following factors could impact an individual's ability to give informed consent?

1. IQ
2. educational level
3. pain medications
4. financial status

(3) Pain medications might alter alertness, thought processes, and reactions. It is recommended that a client be approached for consent at least 4 hours after the last dose of pain medicine to allow minimal impact. IQ and educational level might have a bearing on how information is presented through the discussion process but do not have a bearing on informed consent decision making.

**146.** The only time that an individual may receive medical care without giving informed consent is:

1. when the Durable Power at Attorney for Healthcare is not available.
2. in an emergency life or death situation.
3. when the physician is not available for discussion with the client.
4. when they (clients) are not able to speak for themselves.

(2) Treatment may be given without consent in a life-threatening situation. All attempts to notify a Durable Power of Attorney for Healthcare will be made. If not available, the physician assumes responsibility for treatment within facility protocol. The physician is obligated to have a discussion with the client in all nonlife-threatening situations. If clients are not able to speak for themselves, their Power of Attorney for Healthcare or responsible party is involved in the consent process.

**147.** Informed consent:

1. is always verbally obtained.
2. must be obtained in writing only.
3. includes an explanation of the intended procedure.
4. includes an explanation of the procedure, and the client must understand the potential outcome including harmful results.

(4) The process of obtaining informed consent includes a discussion of the procedure and possible consequences. Informed consent may be obtained verbally, in writing, or be implied.

**148.** Implied consent is a type of informed consent in which:

1. a client has listened to an explanation of a specific procedure and has agreed to allow the procedure to be carried out.
2. a client has listened to an explanation of a procedure and states that he will sign a consent form in 24 hours.
3. a client agrees with the goals of care and, thus, agrees to any/all treatments that will help accomplish those goals.
4. only a client having surgery requires.

(1) Implied consent is obtained for routine procedures—many of which are nursing—for example blood pressure monitoring, finger stick glucose monitoring, and dressing changes. Consent is informally expressed by the client as they are in acceptance of the procedure taking place. There is no specific formal documentation. Surgical procedures require formal, documented informed consent.

**149.** Key component activities of informed consent are:

1. discussion with the physician regarding risks, benefits, and possible outcomes of the procedure and witness to signature.
2. client reading pre-op brochure and witness to signature.
3. explanation of what is to be done.
4. the nurse signing the consent form with the client and completing the pre-op checklist.

(1) Key activities are both obtaining the consent through a discussion process and witnessing consent as described. Obtaining consent must be done personally. Supplemental teaching aids may be used to reinforce or elaborate important points but cannot take the place of personal explanation.

**150.** Mrs. Ruff is having gastric surgery in the morning. Obtaining her consent for the surgery is the role of:

1. the nurse taking care of the patient.
2. the operating room staff.
3. the primary care physician.
4. the surgeon.

(4) The surgeon is responsible for the explanation of what is to be done and the risks of the procedure to that client, along with alternative procedures and probable outcomes. The nurse taking care of the patient can clarify, define a medical term, or add more details to the physician's initial information, usually expanding on the corresponding nursing care. The operating room staff does not have a role in the consent process, nor does the primary care physician.

**151.** Obtaining consent is not a nursing function because:

1. the nurse may not know the exact methods the surgeon will use.
2. it is not considered nursing care.
3. nurses' knowledge and scope of practice are limited.
4. the physicians like to be in charge.

(3) Nursing is not trained or licensed to practice medicine. Only the physician can accurately explain what will be done and the risks of the procedure along with alternatives and probable outcomes.

**152.** Witnessing consent:

1. requires two signatures.
2. must be done by an RN.
3. has no age specifications or limitations.
4. implies that you have observed the client personally signing the consent form with no coercion.

(4) Signing witness to a consent implies willing signature of the client. Only one signature is required as a witness. The witness does not have to be an RN. A witness is required to be over the age of 18.

**153.** All of the following are myths regarding informed consent except:

1. informed consent is designed primarily to protect the legal interests of the medical staff.
2. the most important part of the informed consent process is signing the form.
3. after the consent is signed, the client is committed to the procedure.
4. no one, not even medical experts, can predict whether a treatment, screening, prevention, or supportive care method will prove successful. The informed consent process is designed to support the individual's best choice for themselves.

(4) Regardless of expertise, there is never a certainty regarding outcomes because of the uniqueness of the client's holistic health state. Each person must assimilate the information and make the best choice for themselves. Informed consent is designed to protect the client or consumer of healthcare. The most important part of the informed consent process is the discussion that occurs between the provider of care and the client. Informed consents are revocable at any time for any reason.

**154.** Once signed, informed consents are legally valid:

1. as defined by facility policy.
2. for one year.
3. until discharge.
4. for 30 days.

(1) Facility policy addresses this most usually with a policy statement that indicates that the consent is valid as long as all the circumstances are the same. If a client's status should change, for example, thus changing the risks, a new informed consent would need to be obtained.

**155.** A wrong committed by a person against another person or his or her property, which generally results in a civil trial is:

1. a tort.
2. a crime.
3. a misdemeanor.
4. a felony.

(1) Torts are common patient offenses. A crime is also defined as a wrong against a person or his or her property, considered to be against the public as well. Misdemeanors are crimes that are commonly punishable with fines or imprisonment for less than 1 year, with both, or with parole. A felony is a serious crime punishable by imprisonment in a state or federal penitentiary for more than 1 year.

**156.** There are many types of torts that can be committed against patients. They include all of the following except:

1. assault.
2. battery.
3. negligence.
4. felonies.

(4) Felonies are serious crimes punishable by time imprisoned. Types of torts are: assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.

**157.** The acts enacted by states to provide immunity from liability to persons who provide emergency care at an accident scene are called:

1. Good Samaritan.
2. HIPPA.
3. Patient Self Determination Act (PSDA).
4. OBRA.

(1) The Good Samaritan Laws protect providers of care in an emergency situation. HIPPA's focus is confidentiality of information and right to privacy. The PSDA concerns a patient's autonomous decision making. OBRA was passed in the late 1980s to promote nursing home reform due to quality issues.



**158.** What type of tort is committed when a nurse is intentionally physically rough with a resident in the nursing home following the patient's fifth incontinent episode during the morning?

1. slander
2. battery
3. fraud
4. negligence

(2) The nurse is guilty of battery, which is legally defined as touching someone without consent. Slander is verbalizing a false statement about another that harms their reputation. Fraud is misrepresentation of the truth. Negligence is a care-less act of omission or commission that results in injury to another.

**159.** Malpractice is:

1. the improper performance of professional duties that results in injury to another.
2. a type of documentation.
3. advice given to a neighbor.
4. care given to a patient that results in a positive clinical outcome.

(1) Malpractice contains the four elements of duty, breach of duty, standard of practice, and negative outcomes or damages.

**160.** Which of the following is the federal law that requires hospitals to request patients for advance directives?

1. PSDA
2. HIPPA
3. Social Security Act
4. TEFRA

(1) HIPPA is a recent legislation designed to mandate protection of patient information and right to privacy. The Social Security Act was set up to establish national and state health insurance programs for certain segments of the population (Medicare and Medicaid). TEFRA was a law in the early 1980s that set up prospective reimbursement based on DRGs.

**161.** A nurse is required by law to report to designated authorities all of the following except:

1. child abuse.
2. older adult abuse.
3. certain communicable diseases.
4. suspected negligence of a colleague.

(4) The law does mandate that a nurse report child abuse to Children's Services; older adult abuse to Adult Protective Services; and communicable diseases to the Center for Disease Control (CDC). Suspected negligence of a colleague is not in the realm of mandatory reporting to authorities, but the nurse should discuss with the supervisor.

**162.** Mr. T is taking HCTZ. His blood pressure is 92/64. Based on this reading the nurse should:

1. give the medication as ordered.
2. hold the medication and call the physician for further direction.
3. give the patient the choice on whether or not to take the medication.
4. discontinue the medication based on nursing judgment.

(2) The correct response is to hold the medication and notify the physician for his/her awareness and further direction. The other responses are inappropriate and wrong according to nursing practice guidelines.

**163.** The physician writes an order that the nurse recognizes as not making sense in the patient's care plan. The nurse should:

1. follow the order as written.
2. disregard the order.
3. not complete the order and document the reason in the patient's chart.
4. notify the supervisor per facility protocol and contact the physician to discuss concerns.

(4) If a nurse disagrees with an order written by a physician, he/she is obligated to notify the physician to discuss concern. The nurse should also let the immediate nursing supervisor know of his/her actions. A nurse should always use her nursing judgment and not follow orders that he/she doesn't understand or believe to be in the best interest of the patient. The nurse is not in a position to independently choose to ignore the order without further follow through.

**164.** You are helping the charge nurse pass medication when Mrs. C asks for a pain pill. Going to the narcotic box, you find a discrepancy in the number of pills remaining versus the documentation on the narcotic sheet. Your appropriate action is to:

1. give Mrs. C the pill and document later.
2. immediately report the discrepancy to the nursing supervisor/designee per facility protocol.
3. document your best guess as to who/when the medication was given.
4. tell Mrs. C she can't have her pill now.

(2) A discrepancy of the narcotic count, if not easily resolved at the time of discovery, should be reported to the nursing supervisor as guided by facility policy. From that point, his/her direction should be followed. It is incorrect to administer the medication and document later. The patient should not be denied care. Accounting for narcotic or scheduled medication doses is a serious concern that should not be handled by a best guess.

**165.** The statute of limitations is a time limit:

1. not used in healthcare malpractice cases.
2. in which a lawsuit may be filed for court action.
3. that is 5 years or 60 months from the date of occurrence.
4. that applies to physicians only.

(2) The statute of limitations as established by state law is the period of time following an incident that a lawsuit may be filed. It applies to all healthcare providers.

**166.** A 45-year-old Type 1 diabetic is in need of support services upon discharge from skilled rehabilitation. Which of the following is an example of such a service?

1. shopping for groceries
2. house cleaning
3. transportation to physician's visits
4. medication instruction

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

**167.** Referral for patient education in the community may be accomplished through all of the following except:

1. community agencies such as the American Heart Association.
2. parish nurses.
3. home healthcare agencies.
4. unlicensed massage therapist.

(4) Patient education should be completed by an individual or individuals with acknowledged expertise in the subject area and credentials to support activity within the healthcare community.

**168.** Your 85-year-old client is eligible for Medicare-reimbursable home care services. Referral is contingent upon meeting which of the following criteria?

1. is homebound and requires skilled therapy care
2. immediate previous hospitalization for acute care
3. age
4. requires nursing and social work support

(1) The requirements for Medicare-reimbursable home care services include that the client is homebound and must require a skilled service such as PT/OT/ST/nursing/social work.

**169.** You have been assigned to Mrs. Jacobs as her home care nursing case manager upon her discharge from the hospital. Your role includes:

1. following the plan of care as relayed from the hospital.
2. independently collaborating with and directing other healthcare team members.
3. following the direction of the physical therapist who is the team leader for Mrs. Jacobs.
4. saving the client money by buying supplies in case lots.

(2) The role of the home care nursing case manager is to independently assess the needs of the client, collaborate with the team in planning for and implementing care strategies, and direct and evaluate strategies to meet the team goals.

**170.** The challenges of community case management include all of the following except:

1. limited caseload due to shifting care environments to long-term care.
2. obtaining funding for client needs in the community.
3. coordinating multiple services and providers in a timely manner.
4. maintaining service provision with limited staffing alternatives.

(1) The challenges of community case management include obtaining funding, timely coordination of services, and the availability of qualified staff to deliver care. Case loads are actually shifting toward the community and away from inpatient and long-term care settings.

**171.** Referrals for community-based skilled care:

1. are not necessary for skilled care.
2. must be written by a physician.
3. are not specific to an agency or type of skilled service.
4. may be completed at the completion of the skilled service.

(2) A referral for skilled care in a community-based agency is required to be completed by a physician prior to the start of services and have specific direction for the skilled service to be provided.

**172.** In community case management, the role of the nurse as a case manager is:

1. to follow through with care as defined by the physician.
2. as a provider of direct patient care.
3. to collaborate with the physician for needed medical interventions.
4. to complete insurance forms.

(3) In community case management, the nurse case manager is an indirect provider of care responsible for assessing, coordinating, implementing, and evaluating the care of the client. She/he collaborates with the physician and care team to meet the client goals.

**173.** The nurse discharge planner in your acute care hospital has made arrangements for the discharge of your patient to a long-term care facility based on the patient's needs and wishes. Your responsibility as the nurse caring for the patient includes:

1. notification of the patient's insurance agency of the impending discharge.
2. completion of the acute care agency's referral forms prior to the patient's discharge.
3. calling the patient's pharmacy for the delivery of medications to the home.
4. notification of the primary care physician of the patient's discharge.

(2) The nurses caring for the patient are not responsible for insurance or primary care physician notification of a patient's discharge from acute care. You are responsible for the completion of documentation between the acute care agency and the agency referred to for continuity of care. Pharmacy notification for medication delivery to home is not required at this time because the patient is not going home now.

**174.** Your patient has end-stage colorectal cancer and is going home to die. Referral to which agency is the most appropriate?

1. hospice
2. home care
3. physical therapy
4. respite care

(1) Hospice referral is appropriate for terminally ill patients who require assistance at home. Some home care agencies may provide these services if no hospice is available. Respite care is care of a patient so that the caregiver may complete other functions or take a break from providing care, usually provided by an unlicensed attendant. Skilled physical therapy is not a priority usually at this stage in terminal care.

**175.** Which of the following are sources for the completion of referrals for continuity of care?

1. skilled therapy notes
2. nursing assessments
3. physician orders
4. all of the above

(4) Sources of information for completion of continuity of care referrals include the patient, the chart notes from various providers, assessments and evaluation of need for the patient, and the specific orders of the physician.

**176.** Which of the following information provided to the patient prior to discharge might decrease their anxiety about referral to a community home care agency?

1. the contact person's name and phone number in the community home care agency that will be providing care
2. the date and time of the first expected visit from the agency
3. written instructions regarding the care the patient should expect to receive from the home care agency
4. all of the above

(4) All specific contact information for both the discharging agency and the agency to which the patient is being referred should be given to the patient so that they may contact the agencies if needed. An expected appointment date for the home care agency to first visit the patient helps to establish continuity between the agencies.

**177.** The greatest time savers are all of the following except:

1. reacting to the crisis of the moment.
2. setting goals.
3. planning.
4. specifying priorities.

(1) The greatest time savers are those things that encourage focus and completion of priority items for patient care. These include setting goals and priorities, planning work, delegating where appropriate, and reassessment and evaluation of needs as the plan is enacted.

**178.** Delegation of tasks to appropriate personnel allows the nurse to:

1. take a break.
2. keep other members of the team productive.
3. maintain tight control of all aspects of the workflow.
4. realize the importance of her role by making all decisions.

(2) Maintaining the productivity of all team members by delegating tasks appropriate to the job descriptions of the personnel increases work effectiveness and efficiency.

**179.** In order to manage time most effectively, the nurse responds to urgency expressed by:

1. the physician's loud verbal direction.
2. the nursing supervisor who is going to a meeting.
3. unit staff leaving on a break.
4. the care needs of the returning post-operative patient just exiting the elevator.

(4) Although many environmental stimuli may compete for attention and time, the patient care needs of complex or unstable patients and those requiring assessment and care must take priority.

**180.** Ineffective time management may lead to all of the following except:

1. nursing burnout.
2. perfection.
3. physical illness.
4. interference in relationships.

(2) Ineffective time management does not lead to perfection in either the personal or professional lives of nurses. However, it might lead to burnout in career, physical problems, psychological illness, and/or interference in relationships with others.

**181.** The realities of time management and multi-tasking in nursing require the nurse to possess skills in:

1. denial.
2. priority-setting.
3. avoidance.
4. dealing with guilt.

(2) In order to effectively deal with the current nursing world and the complex care delivery requirements of patient care, the nurse's ability to effectively set priorities is essential.

**182.** Time is:

1. an unlimited resource.
2. an ineffective resource.
3. a finite resource.
4. unmanageable.

(3) Time is a finite resource that must be managed effectively and efficiently in order to best meet the needs of the clients cared for by the nurse.

**183.** The best time manager:

1. utilizes an individualized approach to using time, best fitted to one's personal needs.
2. is the oldest nurse.
3. is the nurse with the most experience working on the unit.
4. uses the same priority plan each day.

(1) The best nurse time manager will use an approach to care delivery, which is individualized to fit the patient's needs, which fits his or her personal needs, and which realizes the integration of multiple competing duties in the completion of the plan. The most experienced or oldest nurse is not necessarily the best time manager.

**184.** "Monkies" are situations that come about as a result of our own failure to do a task right the first time. Ways to avoid "monkies" include all of the following except:

1. complete all of the work yourself.
2. utilize effective delegation.
3. match the right task to the right personnel for delegation.
4. complete task responsibilities instead of utilizing a fragmented approach.

(1) Avoidance of "monkies" includes effective delegation strategies and effective time management strategies such as task completion rather than fragmentation.

**185.** The outlook that avoidance of a task will allow the task to go away is:

1. denial.
2. procrastination.
3. priority-setting.
4. organization.

(2) Procrastination is the avoidance of a task by setting it back for completion later. It is not an effective method of organization or priority-setting and might set the nurse up for poor job performance outcomes.

**186.** Reasons for procrastination include all of the following except:

1. lack of knowledge or skill.
2. fear.
3. insubordination.
4. poor time management skills.

(3) Procrastination may be caused by lack of knowledge, poor time management skills, fear of the thing to be done, competing priorities, and overload.

**187.** In the upcoming decades, the number of persons requiring more complex healthcare will increase. As we face the limitations of finite fiscal resources, which of the following ethical issues will increase in urgency?

1. autonomy
2. beneficence
3. rationing of limited resources
4. fidelity

(3) The issue of the use of limited resources and correspondingly increasing healthcare needs will be one of the most controversial and critical issues in the upcoming decades.

**188.** Pitfalls and difficulties in supervision are all of the following except:

1. supervisor enjoys facilitating other's work.
2. supervisor engages in excessive supervision.
3. supervisor cannot reconcile the different way in which the individual does the task.
4. supervisor still wants to do it all.

(1) Facilitating the work of those being supervised is a significant goal of a supervisor. One who enjoys that aspect of supervision will have increased effectiveness. Excessive supervision, intolerance for individual style differences, and feeling the need or desire to personally perform the work will interfere with relationships and overall effectiveness.

**189.** Activities of effective supervisors can be task-related or people-related activities. An example of a task-related supervisory activity is:

1. coaching.
2. evaluating.
3. delegating.
4. facilitating.

(3) Delegating is the act (or task) of assigning work to those who are capable and competent to do the work. Coaching, evaluating, and facilitating are supervisory activities that are people related.

**190.** People-related supervisory tasks include all of the following except:

1. coaching.
2. encouraging.
3. target setting.
4. rewarding.

(3) Target setting is the projection of goals or objectives to be accomplished and is considered to be a task-centered supervisory responsibility. Coaching, evaluating, and facilitating are supervisory activities that are people related as they involve direct interaction with those doing the work.

**191.** In preparing the shift's assignment, the nurse is aware that the delegation and supervision of patient care tasks is legally defined by:

1. the state board of nursing.
2. the American Nurse's Association.
3. the AHA (American Hospital Association).
4. facility policy.

(1) Each state board of nursing is responsible for the nurse practice acts. Responsibilities for the various levels (RN and LPN) are defined, including delegation and supervision of patient care tasks. Neither the ANA nor AMA have a role. Facilities may set policies that are more limiting for staff working within their premises, but they may not extend responsibilities beyond the State defined practice acts.

**192.** A nurse supervising care given to a group of patients identifies which of the following as a measure of success?

1. patient care completed in a timely efficient manner with patients perceiving their needs have been met
2. being asked by the staff to participate in a social outing
3. lack of incidents during the shift
4. stability of the patients

(1) A nurse in a supervisory role is responsible for ensuring that care is given appropriately, as ordered with some degree of patient satisfaction. Supervising is not a popularity contest; at times the supervisor may need to portray authority. Lack of incidents per shift is one possible indicator that safety was maintained but is not as significant as answer choice one. The stability of the patients often cannot be controlled by a supervisor—changes occur dependent on the illness or disease.

**193.** It is a busy night in the ICU, which is short staffed due to ill calls. The house supervisor assigns a nurse from pediatrics to fill in. This nurse has never worked in a critical care unit. As the RN making assignments, you should assign which patient to this nurse?

1. an 72-year-old fresh post-op open heart surgery patient, who is having problems maintaining his blood pressure and has considerable chest tube drainage
2. a 63-year-old man, trached with COPD and pneumonia, who is on the vent for total support
3. a 56-year-old woman who 3 days ago had a partial gastrectomy and esophageal resection due to GI bleeding
4. the new admission yet to arrive on the unit from the ER with an admitting diagnosis of blunt trauma

(3) The 56-year-old 3-day post op patient is the best choice for the pediatric nurses assignment because this patient is probably the most stable, and her care involves aspects of care that are generally involved in any post-op patient regardless of age. The post-op open heart patient and the patient on the ventilator require more critical care skills. The new admission that hasn't even arrived on the unit is unknown as to care needs and stability; therefore, it would be optimal to have a critical care nurse assigned.

**194.** As the supervisor to the pediatric nurse who has been floated to help cover in the ICU, what would be your primary role in working with this nurse?

1. taking her to dinner with you
2. orienting her to the location of the unit's linens and supplies
3. helping her to pull a patient up in bed
4. reviewing her assignment with her and discussing her skills

(4) When communicating the patient assignment to the float pediatric nurse, as the supervisor the nurse should spend some time communicating expectations, discussing the unit, unit routines, and any background information about the patient(s) being assigned. Offering her company at mealtime would be a very nice gesture, but not a primary goal. Orienting her to the location of supplies would be a helpful gesture, but this could be delegated to an UAP. Assisting her with care (that is, pulling a patient up in bed), would be a good way to observe her interaction with patients as well as offering bedside support.

**195.** As the RN assigned to night shift on a general med-surg unit, one of the nursing assistants reports that they are concerned about one of the LPNs. The nursing assistant witnessed this LPN coming out of a strict isolation room with gowns, masks, and gloves still on. She went down the hall to the med cart, unlocked it to get something, and then stopped to chart. She proceeded to re-enter the patient's room and approach the bedside to continue care. The nursing assistant is worried that this LPN may be spreading infection. As a supervisor, you would:

1. do nothing. It is within the LPNs scope of practice to work with patients in isolation.
2. confront the LPN with the report to get her side of the story.
3. realize that this LPN has been newly hired from home care. Have a conversation with her, asking for her to clarify her understanding of isolation procedures.
4. thank the nursing assistant, and ask her to let you know if she sees the LPN do it again.

(3) Since many procedures in home care are not performed with strict sterility, it would be appropriate for the nurse to clarify the LPN's understanding of the concept of sterile technique as required by strict isolation. To ignore the aide's report would be to allow the problem behavior to potentially continue. If a knowledge deficit exists, then education and support is appropriate. Confrontation in this case would not be positive as it could become accusatory and have negative team effects. It is not appropriate to ask the nursing assistant to monitor the LNP's performance; that is the role of the supervisor.



**196.** The nurse is assigning the care of a patient with a Foley catheter to the unlicensed assistant (UAP or nursing assistant). Which of the following responsibilities cannot be delegated to the UAP?

1. routine catheter care
2. emptying the Foley bag at the end of the shift
3. reinserting the catheter if the patient pulls it out
4. securing the drainage tubing on the bed in order to avoid dependent loops

(3) A Foley catheter must be inserted by an RN or LPN. Routine catheter care, emptying the Foley drainage bag, and securing the tubing to maintain patency and prevent backflow can be safely delegated to the UAP.

**197.** An 80-year-old patient is scheduled for a colonoscopy. Which of the following pre-procedural activities would be appropriate for the nurse to delegate to the unlicensed assistant (UAP or nursing assistant)?

1. instructing the patient about the procedure
2. assisting the patient to the bathroom to ensure safety
3. obtaining the informed consent
4. discussing the potential diagnoses with the family

(2) It would be appropriate for the nurse to instruct the nursing assistant to assist the patient to the bathroom to promote safety and minimize fall potential. It is the responsibility of the physician performing the procedure to obtain the informed consent. It is the responsibility of the registered nurse to teach patients and families regarding the diagnosis and treatment plan. These responsibilities cannot be delegated to UAPs.

**198.** A nurse assigns a confused, older adult with a diagnosis of early dementia to a UAP. The nursing assistant states, "I will, but I've never taken care of anybody like that before." Sensing the UAP's discomfort, the role of the nurse in providing supervision is to:

1. ask the nursing assistant for a full report at the end of the shift.
2. tell the nursing assistant that the nurse will cover for dinner time.
3. go into the patient room with the nursing assistant for the first time and role model methods of communication with the patient as care is given.
4. assign the nursing assistant to another patient.

(3) The nurse must decide whether the nursing assistant has the skill set to take care of this patient. If she proceeds with the assignment the supervisor should take some time and discuss care strategies for this patient and offer the nursing assistant help. Role modeling communication techniques would be a helpful educational strategy. To reassign the patient would not give the nursing assistant the opportunity and experience for his/her growth.



# Safety and Infection Control

This chapter contains questions and answers from the following topic areas:

- Accident/Error Prevention
- Disaster Planning
- Emergency Response Plan
- Error Prevention
- Handling Hazardous and Infection Materials
- Home Safety
- Injury Prevention
- Medical and Surgical Asepsis
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plans
- Standard/Transmission-Based/Other Precautions
- Use of Restraints/Safety Devices

**1.** Which of the following ethnic group is at higher risk for pesticide-related injury?

1. Native American
2. Asian-Pacific
3. Norwegian
4. Hispanic

(4) Because of the predilection toward outside and agricultural jobs, migrant workers, made up mostly of Hispanic people, this group is at higher risk for exposure.

**2.** The nurse will teach parents of small children that the most common type of first-degree burn is:

1. scalding from hot bath water or spills.
2. contact with hot surfaces such as stoves, fireplaces.
3. contact with flammable liquids and/or gases resulting in flash burns.
4. sunburn from lack of protection and overexposure.

(4) The most common type of first-degree burn is sunburn underscoring the need for education regarding the use of sunscreens and avoiding exposure.

**3.** The nurse will teach the community-based client that the most common cause of injury from a house fire is:

1. explosion.
2. falls from second-story windows.
3. thermal damage to skin and body surfaces.
4. inhalation thermal injury.

(4) Inhalation thermal injury is associated with significant morbidity and mortality. Manifestations might not show up until 24 hours post exposure.

**4.** Acute hyphema is associated with what type of injury?

1. orthopedic
2. eye
3. insect sting or snakebite
4. gynecological trauma

(2) An acute hyphema occurs as a result of a blunt injury to the eye and is manifested by a horizontal line of demarcation across the globe when the patient is upright. The manifestation occurs due to blood collected in the anterior chamber.

**5.** The patient has sustained a hyphema; what intervention should the nurse take?

1. Have client wear ear protectors in the future.
2. Keep the client at bed rest typically with head of bed up.
3. Apply atropine eye drops.
4. Apply an ice pack to the site of injury.

(2) Initial care of the patient involves preventing further damage and rebleeding. Patients are kept at bed rest if possible and usually with the head of bed raised. TV watching is permitted but not reading. The use of atropine, ice, and eye shields are controversial, and a nurse would not prescribe a pharmacologic agent or thermal therapy although the nurse may administer a physician's or a nurse practitioner's order.

**6.** The nurse's first action upon discovery of an electrical fire is which of the following?

1. Disconnect the electrical power if this can be done safely.
2. Smother the source with an object such as a blanket.
3. Saturate the source with water or other liquid readily available.
4. Activate the fire alarm immediately.

(1) If safe to do so, the nurse should disconnect electrical devices from the power source. Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire just as water or other liquids may incite an explosion or flames. The fire alarm should be activated promptly and would be the next action after disconnecting the electrical powered equipment.

**7.** How many feet should separate the nurse and the source when extinguishing a small, waste basket fire with an appropriate extinguisher?

1. 1 foot
2. 2 feet
3. 4 feet
4. 6 feet

(4) The nurse should stand about 6 feet from the source of the fire. Getting much closer might put the nurse in danger.

**8.** While repositioning a comatose client, the nurse senses a tingling sensation as she lowers the bed. What action should she take?

1. Unplug the bed's power source.
2. Remove the client from the bed immediately.
3. Notify the biomedical department at once.
4. Turn off the oxygen.

(1) Shutting off the bed's electricity should be the initial step. The nurse should not touch the client until the bed is checked for faulty grounding. An electrician should assess the equipment. Oxygen should be discontinued until the equipment is cleared.

**9.** After securing the client's safety from a faulty grounded electric bed, the nurse will take which action?

1. Discuss the matter with the client's significant others.
2. Document the incident in the client's record in detail.
3. Notify the physician.
4. Prepare an incident report.

**(4)** When the situation is safe for the client, the nurse should record the occurrence on an incident form according to the agency protocol.

**10.** The nurse is documenting a H-E-A-D-D-S-S inventory on the client. In which age group does the client fit?

1. preschool
2. middle childhood
3. adolescence
4. college age

**(3)** The HEADDSS (home, education, activities, drugs, driving, sex, suicide) assessment acronym applies primarily to adolescents, although it might be used in the middle-childhood and college-age categories if deemed appropriate.

**11.** One afternoon, an adult male with no history of past medical conditions arrives by ambulance in cardiac arrest after being discovered unconscious in his backyard. The nurse notes his skin to be warm and moist to touch, diffusely swollen with multiple punctate lesions of the lower extremities. A likely cause of the emergency is:

1. pulmonary embolus.
2. head trauma.
3. envenomation.
4. myocardial infarction.

**(3)** Hymenoptera (bees, wasps, ants) envenomation can cause local and systemic allergic reactions including anaphylaxis, shock, and cardiac arrest. The history of being found outdoors suggest the possibility of an insect or viper bite(s).

**12.** To ensure patient safety when making an occupied bed, the nurse will place the side rails in which of the following positions?

1. both side rails in the lowered position
2. the side rail opposite the nurse's working area in the lowered position
3. both side rails in the raised position
4. the side rail opposite the nurse's working area in the raised position

**(4)** Placing the side rail up on the side opposite the nurse will prevent the patient from falling. While raising both side rails would also prevent a fall, the nurse would place the client and herself at greater risk for injury by attempting to work over a raised side rail.

**13.** Which of the following indicators increases the elderly client's risk for falls?

1. cranial nerve five dysfunction
2. negative orthostatic vital signs
3. negative Romberg's sign
4. diagnosis of urinary tract infection

**(4)** Urinary tract infections in the elderly are associated with sensorium changes that increases the risk of falls. Cranial nerve eight (not five) dysfunction would indicate equilibrium changes as a positive Romberg sign and orthostatic vital signs.

**14.** Which of the following risk factors is significant for predicting domestic violence in the adult population?

1. married individuals
2. lower socioeconomic status
3. history of domestic violence in childhood
4. no professional education or vocational training

(3) Domestic violence strikes all social and educational strata and includes dating and intimate partner violence. The strongest predictor of adult domestic violence is a history of observing or being victimized in childhood.

**15.** While assessing a Vietnamese child in the emergency department, the nurse notes erythematous, linear markings on the torso. As the caregiver explains how she put them there to treat fever, the nurse suspects:

1. cupping.
2. coining.
3. accidental trauma or child abuse.
4. chelation.

(2) Certain Asian groups practice the technique of coining, rubbing the skin vigorously with a coin until a red mark occurs. *Cupping* is treatment for arthritis practiced in some cultures. *Coining* may be mistaken for child abuse if cultural practice is not assessed. *Chelation* is a medical technique of removing iron and heavy metals from the body in poisoning.

**16.** During a well infant check-up, the RN notes ecchymotic, bluish markings across the buttocks and sacral region of a dark-skinned infant. The markings most likely represent what skin condition?

1. child abuse pattern injury or soft tissue trauma
2. petechiae
3. Mongolian spots
4. Koplik's spots

(3) Mongolian spots are a normal skin variation often seen in dark-skinned newborns and infants. Petechiae is a red, punctate lesion associated with capillary breakage while Koplik's spots are associated with strep and found in the pharynx.

**17.** During a well infant check-up, the RN notes a religious amulet around the client's neck. What is the best response to the caregiver?

1. "Can you tell me about the necklace?"
2. "This is a choking hazard."
3. "Let me get this off."
4. "Why did you put this around the baby's neck?"

(1) Asking about the significance of the amulet in a nonthreatening manner is the first step in conveying respect for the client's religion/culture. Immediately passing judgment and instructing against the use of the necklace rejects the individuality of the client and their ethnic diversity. Asking why as the initial response does not convey acceptance and might impair communication and incite client defensiveness.

**18.** The RN is developing a community accident prevention program related to older adult premature death. Which of the following topics will be presented?

1. drowning
2. burns
3. influenza
4. motor vehicle accidents

(4) Motor vehicle accidents pose the greatest risk for death of the listed options. Burns and drownings are much less frequent in the older adult, although they can occur, and influenza is a medical illness.

**19.** The nurse instructing a new parent on the proper positioning of the infant car seat will explain that the infant or child may be positioned forward facing in an automobile at what weight?

1. 6 kg (12 lbs)
2. 7.5 kg (15 lbs)
3. 9 kg (20 lbs)
4. 10 kg (22 lbs)

(3) Positioning of the car seat is based on body weight and age. At 20 lbs (9 kg), the infant or child 12 months or older may be placed in a forward-facing child seat.

**20.** A lifeless child is brought unconscious to ER with resuscitative efforts in progress. In considering the etiology of childhood deaths, which of the following is the most likely cause?

1. poisoning
2. congenital defects
3. accidents
4. influenza

(3) Accidents (particularly motor vehicle) are the leading cause of death for all age groups from toddlerhood to adulthood. Poisoning while significant for this age group, is not as prevalent. Deaths from congenital defects occur most often in the neonatal and infancy stages. Influenza deaths, while possible, are much more uncommon in children. In assessing a patient in a critical illness or injury situation, the nurse brings her knowledge of age-specific causes of death.

**21.** Community accident prevention education will include which of the following facts regarding the most prevalent cause of accidental death from age 1–44?

1. drowning
2. burns
3. motor vehicle accidents
4. firearms

(3) Accidents are the number one cause of death for ages 1–44 with motor vehicle accidents accounting for the majority, while congenital conditions and medical illnesses claim the youngest and the oldest.

**22.** The nurse providing safety instruction to a local daycare explains that the leading cause of death for preschool children is:

1. drowning
2. burns
3. falls
4. motor vehicle accidents

(4) Motor vehicle accidents are the leading cause of death for all races and both sexes in the 1–44 year old age group.

**23.** A frantic caregiver calls the office and asks the nurse, “What should I do, my two year old just drank Drano?” The nurse’s correct response is:

1. “Is the child conscious?”
2. “Relax. It will be okay.”
3. “Is the child breathing?”
4. “Induce vomiting immediately.”

(1) The nurse's correct first response is to have the caregiver determine unresponsiveness, initiate BCLS if needed and call 911. Assessment is the first step in applying the nursing process.

**24.** The nurse teaching a parenting class instructs that the hot water temperature in the home should be at what degree to prevent thermal burns?

1. 100°F
2. 120°F
3. 140°F
4. 150°F

(3) To prevent thermal burns and scalding, hot water thermostats should be set at 120 or less. Adult skin can tolerate temperatures somewhat higher (that is, 140 or less). The class here involved parents of children.

**25.** Which of the following is the leading cause of accidental injury in the elderly?

1. falls
2. motor-vehicle accidents
3. firearm related trauma
4. unintentional overdose

(1) Falls in the elderly are the leading cause of accidental injury and are associated with a large number of nursing home and hospital admissions. The other choices are possible causes but are much less common in the age group.

**26.** While eating in the hospital cafeteria, the nurse sees a visitor display the “universal sign of choking.” Her first action is:

1. page a “Code Blue” emergency.
2. immediately perform the Heimlich maneuver.
3. assess for ineffective breathing by asking, “Are you choking?”
4. deliver four sharp back blows between the scapulae.

(3) The nurse's first response is to assess that the person is actually choking and then rapidly proceed to intervene using the Heimlich. Back blows are not indicated in adults with obstructed airways and might actually create a complete obstruction by dislodging a foreign body that was only partially blocking the airway.

**27.** While eating in the hospital cafeteria, the nurse sees a visitor fall from a chair in the midst of a tonic-clonic seizure. Her first action is:

1. page a “Code Blue” emergency.
2. position the visitor laterally and restrain the extremities to prevent injury.
3. assess for airway effectiveness and position the visitor laterally.
4. shake the visitor vigorously and establish unresponsiveness.

(3) The nurse should calmly position the patient to protect the airway while assessing the effectiveness of airway and breathing. During the tonic-clonic phase of a seizure, breathing might be temporarily decreased or absent. Seizure activity is typically brief, and breathing spontaneously returns when it ceases. Occasionally, oxygen support is needed. The patient should be evaluated by an emergency services provider or her personal healthcare provider.



**28.** The nurse discovers a waste basket fire in the room of a sleeping patient. What action should be taken immediately?

1. Remove the patient to safety.
2. Report the fire.
3. Extinguish the fire.
4. Check the patient for breathing and circulation.

(1) Ensuring patient safety from the fire must be the initial action. Even if the patient has sustained airway compromise and/or needs resuscitation, he will first have to be in a safe environment before steps can be taken. If a fire is small, current recommendations are that the nurse should extinguish it by covering the fire with a blanket, closing the door or using an extinguisher aimed at the base of the fire. She should never place herself in increased danger of harm. A good rule of thumb is the acronym R-A-C-E. **R**emove the patient, **s**ound the **a**larm, **c**ontain the fire (or close the door), and consider whether to extinguish the fire or to **e**vacuate the building.

**29.** The nurse recognizes which correct principle guiding the use of side rails?

1. Side rails are used mainly as a precaution against falls in the elderly.
2. Side rails are a form of restraint.
3. Side rails should be up at all times if a patient is at risk for falling.
4. No special consent is necessary for the use of side rails.

(2) Side rails are restraining devices and might contribute to falls in many circumstances. Typically, an increased risk for falling has been identified and a physician's order obtained prior to their use. The use of side rails should be based on the agency's policy and the needs of the patient. For example, a patient who has received a sedative hypnotic or mood altering medication would likely need side rails to decrease the risk of falling.

**30.** What kind of agent is sarin?

1. a neurotoxin
2. a blister agent
3. a respiratory (choking) agent
4. a blood agent

(1) Sarin is a neurotoxin (a nerve agent). Nerve agents enter the body primarily through inhalation but can also be absorbed, ingested, or injected (including entering through open wounds). Sarin is a colorless, odorless liquid.

**31.** Smallpox is contagious:

1. from the time the rash develops until the scabs are gone.
2. only until the rash begins to appear.
3. from 1 week before the rash develops until the scabs are formed.
4. within 24 hours of first coming into contact with the virus.

(1) Smallpox is contagious from the time the rash develops until the last scab falls off; incubation period is 7–17 days (typically 10–12 days) before onset of illness with 2–4 more days to onset of rash.

**32.** Anthrax exposure was seen by a community health nurse in a clinic in the west. The following symptoms were all seen except:

1. black sores and blisters on hands and forearms (cutaneous skin).
2. chest cold or flu symptoms, respiratory distress (inhalation).
3. intense abdominal pain, bowel obstruction (gastrointestinal).
4. eye damage and loss of sight (optic).

(4) Anthrax is transmitted by handling contaminated wool, hides, ticks, or tissues of infected animals or by inhaling or ingesting bacterial spores. Options 1, 2, and 3 all are symptoms of Anthrax acquired through cutaneous, inhalation, and gastrointestinal means.

**33.** Which biological agent occurs when food is contaminated?

1. Tularemia
2. blister agents
3. plague
4. Salmonella

(4) Salmonella is transmitted by contaminated food; GI problems occur with abdominal pain; possible progression to pericarditis, endocarditis.

**34.** The key to handling unexpected emergencies is:

1. have a plan of action.
2. let “nature take its course.”
3. “what will be, will be.”
4. know 911.

(1) If you have a plan of action, knowing what to do can save your life or others; (1) have directions to your house (written), (2) post emergency numbers, (3) prepare emergency information sheets, (4) don’t delay calling for help, (5) know CPR, Heimlich maneuver, (6) be patient but assertive, (7) no food or drink, unless patient is a diabetic, (8) don’t move trauma victims.

**35.** In regard to safety for emergency care, which of the following statements is most accurate?

1. Bacterial contamination of foods is uncontrollable.
2. Fire is the greatest cause of unintentional death.
3. Temperature extremes seldom affect the safety of clients in acute care facilities.
4. Carbon dioxide levels should be monitored in home settings.

(4) Carbon monoxide is a colorless, odorless gas that if inhaled for some time can cause death. Option 1—once the contaminated source is found control can be accomplished; option 2—fire is a cause of unintentional death but not the greatest cause (accidents, car, other); option 3—temperature extremes can have an affect on the clients buy might not be a health or safety hazard.

**36.** To organize urgent nursing interventions effectively, the nurse should do all except:

1. assess the situation rapidly; prioritize individuals.
2. triage individuals, so that care can be given in priority.
3. consolidate activities for more effective care.
4. classify problems as a wait (time) will not affect the outcome of treatment.

(4) Every minute of delay could be crucial to the outcome; assess, plan, and intervention evaluation determines client treatment priorities based upon the severity of injury and priority for treatment.

**37.** Treatment for botulism includes all of the following except:

1. airway management.
2. atropine.
3. antitoxin.
4. assisted ventilations.

(2) Atropine is not given to manage exposure to botulinum toxin; signs and symptoms include: dry mouth, difficulty speaking, difficulty swallowing, vision problems, paralysis of diaphragm.

**38.** When is an emergency assessment done by the nurse?

1. all the time, whether the situation is an emergency or not
2. in a disaster situation only
3. during a physiologic or psychologic client crisis
4. when a client asks you to do one

(3) An emergency assessment is done during any physiologic or psychologic crisis of the client and is done to identify life-threatening problems.

**39.** What is the most important assessment that the nurse does with a client during an emergency situation?

1. rapid assessment of airway, breathing, and circulation
2. rapid assessment from head to toe
3. assessment of a client's functional health
4. assessment of a client's vital signs, physical and psychological health

(1) The most important assessment during an emergency situation is airway, breathing, circulation (ABC); this should be done rapidly.

**40.** In an emergency (disaster) situation, before the nurse administers oxygen to a client, she should determine whether the client has a history of:

1. heart failure.
2. peripheral vascular disease.
3. chronic obstructive pulmonary disease.
4. neurological deficits.

(3) Chronic obstructive pulmonary disease (Emphysema) adversely affects pulmonary function; emphysema is a pulmonary condition in which the alveoli are dilated and distended; in clients with chronic obstructive lung disease, administering supplemental oxygen may actually cause the client to stop breathing.

**41.** The nurse in an emergency situation tries to determine whether a client has an airway obstruction. Which of the following should the nurse assess?

1. ability to speak
2. ability to hear
3. oxygen saturation
4. adventitious breath sounds

(1) Ability to speak is a major way to identify an airway obstruction.

**42.** In a disaster situation, when assessing a diabetic client on Insulin, the nurse should assess for all of the following except:

1. diabetic signs and symptoms.
2. nutritional status.
3. bleeding problems.
4. availability of Insulin.

(3) Bleeding problems are not characteristics of diabetes; important is any untoward diabetic signs/symptoms, nutritional status, and availability of Insulin.

**43.** In a disaster triage situation, the nurse would be least concerned with which of the following regarding a client in crisis?

1. ability to breathe
2. pallor or cyanosis of the skin
3. number of accompanying family members
4. motor function

(3) The least importance during an emergency situation would be the number of accompanying family members. The nurse is responsible for the client, considering the ABC-Regime—Airway, Breathing, and Circulation in that order.

**44.** Which of the following clients is *not* in need of an emergency assessment?

1. a bleeding client who has an injury from falling debris
2. an unresponsive client
3. a client with an old injury
4. a pregnant woman with imminent delivery

(3) The client with an old injury would not need an emergency assessment because this is not a life-threatening or new situation (condition).

**45.** A primigravida (a woman pregnant for the first time) begins labor during a disaster situation and is alone. She is very upset that her family is not with her. What approach can the nurse take to meet the client's needs at this time?

1. Ask whether another individual would like to be her support person.
2. Assure her that the nursing triage group will be with her at all times.
3. Tell her you will try to locate her family.
4. Reinforce the woman's confidence in her own abilities to cope and maintain a sense of control.

(1) Allow the client to select another individual to give support. This will allow for her to have someone to be with her until such a time as her family can be with her.

**46.** Signs of internal bleeding include all of the following except:

1. painful, swollen, or deformed extremities.
2. a tender rigid abdomen.
3. vomiting bile.
4. bruising.

(3) Vomiting bile is usually not a sign of internal bleeding. Signs of internal bleeding include painful, swollen, or deformed extremities; a tender rigid abdomen; and bruising.

**47.** Patients with heart problems might complain of any of the following except:

1. pain in the center of the chest.
2. mild chest discomfort.
3. sudden onset of sharp abdominal pain.
4. difficulty in breathing.

(3) Patients with heart problems might complain of pain in the center of the chest, mild chest discomfort, and difficulty breathing. They do not have sudden onset of sharp abdominal pain.

**48.** What are the major ways in which a poison can be taken into the body?

1. ingested, inhaled, absorbed, injected
2. inhaled, absorbed, transdermal
3. transmitted only through the skin
4. transmitted only orally/injection

(1) The major ways that a poison can be taken into the body are (1) Ingested (poisons that are swallowed), including chemicals, medications, improperly prepared foods, others; (2) Inhaled (poisons that are breathed in), including gases, vapors, sprays, others; (3) Absorbed (poisons that are taken into the body through unbroken skin and that may or may not damage the skin), including corrosives, irritants, others; (4) Injected (poisons that are inserted through the skin), including illicit drugs and venoms such as snakes, insects, others.

**49.** The nurse in the Obstetrical Emergency should do which of the following first after the baby delivers?

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

(3) After the baby delivers, you should immediately clear the mouth and nose with gentle suctioning using a bulb aspirator. This is the first and most important of all the options; option 4 is next because warmth helps preserve the body temperature; option 1 is the next most necessary event; in option 2 the cord must be tied in two places before cutting (if scissors are not sterile, cutting the cord could cause a very bad infection to the baby which could lead to death).

**50.** All of the following are causes of vaginal bleeding in late pregnancy except:

1. placenta previa.
2. eclampsia.
3. abruptio placentae.
4. uterine rupture.

(2) Eclampsia is a disorder of pregnancy characterized by hypertension, proteinuria, and edema. This condition can cause seizure and/or coma. Options 1 and 3 are abnormal conditions that can cause bleeding, particularly in the third trimester. Option 4 is a major obstetrical emergency that can cause bleeding internally and externally.

**51.** A newborn in an emergency situation has been delivered. An Apgar score is given. What does this scoring system tell us?

1. heart rate, respiratory effort, color, muscle tone, reflex, irritability
2. heart rate, bleeding, cyanosis, edema
3. bleeding, reflexes, edema
4. respiratory effort, heart rate, seizures

(1) The Apgar Scoring System was put into place by Virginia Apgar, an anesthesiologist in New York, for the purpose of assessing the newborn in the areas of: (1) heart rate, (2) respiratory effort, (3) color, (4) muscle tone, (5) reflex irritability at one minute, five minutes, and some at ten minutes after birth.

**52.** All of the following statements about botulism are correct except:

1. symptoms will begin within 1–12 hours.
2. excessive secretions will be present.
3. botulism is one of the most lethal poisons that can be ingested.
4. botulism is not contagious.

(2) Botulinum toxin blocks release of acetylcholine from nerve endings, causing a decrease in secretions; signs and symptoms include: dyspnea, shortness of breath, apnea from paralysis of diaphragm and intercostal muscles, drooping of eyelids, difficulty swallowing, blurred vision, double vision, and dilated pupils; the rate of action is 1–12 hours and is an emergency (disaster situation).

**53.** Smallpox is spread by:

1. contaminated food.
2. droplets produced by sneezing or coughing.
3. mosquitoes.
4. sexual contact.

(2) Droplets produced by sneezing and coughing transmit the smallpox virus; also, contact with fluids from skin lesions can transmit smallpox; smallpox vaccine can be given prophylactically.

**54.** All of the following statements about cyanide are correct except:

1. two forms of cyanide are used in chemical warfare: hydrogen cyanide and cyanogen chloride.
2. cyanide causes severe respiratory distress, abdominal pain, and a rash.
3. cyanide prevents cells from using oxygen.
4. death may occur within 10 minutes.

(2) Cyanide does not cause abdominal pain or a rash. Cyanosis causes signs and symptoms of severe hypoxia. However, the patient does not become cyanotic, and a pulse oximeter will not show decreased hemoglobin saturation; the military classifies cyanide as a “blood” agent. Cyanide is toxic because it prevents metabolic use of oxygen, causing asphyxiation at the cellular level; hydrocyanic acid and cyanogen chloride are highly volatile and evaporate quickly. The vapors of hydrocyanic acid are lighter than air and disperse rapidly. Cyanogen chloride vapor is heavier than air and will sink into low-lying areas. Cyanide interferes with the body’s ability to use oxygen at the cellular level and causes dyspnea, respiratory depression, apnea, and hypotension, and acidosis.

**55.** A 32-year-old male and his 28-year-old wife are complaining of headache and a cough. A rash consisting of reddened areas surrounding small, fluid-filled blisters is present on their arms, legs, and faces and is beginning to appear on their chests. They spent the last month traveling with a tour group in the Middle East. The male patient’s vital signs are pulse (P)—112, strong, regular; blood pressure (BP)—124/82; respiration (R)—18, regular, unlabored; and temperature (T)—102.6°F. The female patient’s vital signs are P—118, strong, regular; BP—108/76; R—22, regular, unlabored; and T—103.2°F. The nurse approaches this situation and should:

1. not do an initial assessment.
2. call for additional help.
3. do a scene size-up, quarantine the scene, and call for additional help.
4. not be concerned whether you were vaccinated when you were a child.

(3) You should do a scene size-up, quarantine the scene, and call for additional help from law enforcement and the health department. Your principal objective at this point is to prevent the spread of smallpox from these patients to others in the community. Investigators from the health department can begin the process of identifying contacts of these patients to locate other possible cases and of tracing the origin of the infection. Because smallpox does not occur naturally, this event possibly is the result of terrorist activity. Law enforcement should be involved to begin an investigation to identify the parties responsible for the smallpox outbreak. Protection from smallpox vaccination lasts 3–10 years. After this time, booster doses should be given if exposure has occurred. Vaccination is effective up to 1 week after exposure.

**56.** At 8:30 AM on Thursday, several small canisters exploded in a bus station. Later in the day, many of the people who were present at the time of the explosion developed shortness of breath, muscle and chest pain. The hazardous materials (Hazmat) team has determined the canisters contained Ricin. All of the following statements about Ricin are correct except:

1. inhaled Ricin attacks the respiratory system, causing pneumonia and pulmonary edema.
2. ingested Ricin causes gastrointestinal bleeding, which can lead to death.
3. ricin can be produced in an aerosolized form and solid form.
4. symptoms of Ricin toxicity begin 48–72 hours after exposure.

(4) Ricin effects begin in 1–12 hours; Ricin is a toxin isolated from castor beans; Ricin is a potent toxin that can be isolated from the “mash” that remains after castor beans are processed to make castor oil. Two to four castor beans contain enough Ricin to kill an adult. Ingestion of one castor bean can be lethal to a child; Ricin causes tissue necrosis, pneumonia, internal bleeding, and vascular collapse. Ricin is not volatile; therefore, secondary inhalation is not a hazard. However, skin contact should be avoided, and the patient should be washed with diluted bleach solution, soap and water.

**57.** The signs and symptoms of smallpox are similar to those of:

1. measles.
2. meningitis.
3. botulism.
4. chicken pox.

(4) The signs and symptoms of smallpox are similar to those of chicken pox. In chicken pox, the rash appears first on the trunk and spreads to the extremities. In smallpox, the rash begins on the extremities and spreads to the trunk.

**58.** Which of the following events would alert the nurse to biological terror?

1. a client storing loose, white talc in a decorative canister
2. several persons in close proximity, becoming ill simultaneously
3. several persons with flulike symptoms in early January
4. anecdotal reports of dead birds and fish in the local community

(2) Biological terrorism would usually be directed at groups of people, either through water supply, food supply, and so on. It would normally result in many people becoming ill at the same time. White talc could be talc, narcotics, or something more lethal, but would not normally indicate terrorism. In early January, it is likely that there would be many people with the flu. Reports of dead birds and fish would probably be the result of something dangerous and toxic, but biological terrorism is not aimed at wildlife—it is directed at people.

**59.** The client’s culture report is negative for the suspected infection. A test that can correctly identify those who do not have the disease is:

1. specific.
2. sensitive.
3. negative culture.
4. marginal findings.

(1) Testing or instrumentation that identifies those without the disease is specific while those tests that identify those with the disease are sensitive. A marginal finding could mean that a test is weakly positive and may need repeating for reliability and validity.

**60.** Based on sensitivity and specificity findings, the client is told that his test is positive, but in fact, the client does not have the disease. Which type of error is this an example?

1. true positive
2. false positive
3. true negative
4. false negative

(2) A false positive occurs when a person is labeled positive who does not have the disease. A test that identifies the absence of the disease is specific while a test that identifies the disease is sensitive. False positives are more common than false negatives as clinical testing must be extremely sensitive to identify all persons with the disease. Testing or instrumentation that identifies those without the disease is specific while those tests that identify those with the disease are sensitive.

**61.** The nurse teaching a course on medication errors and drug overdose will report that the vast majority of deaths resulting from unintentional poisoning (or overdose) occurs in:

1. infants.
2. toddlers.
3. teens.
4. adults.

(4) The elderly make up the greatest number of persons who die of drug overdose. Elderly persons are often given dosages derived from healthy adult studies that do not account for the organ dysfunction and impairment associated with aging. Further, sensory deprivation and other physical impairments make them at greater risk for unintentional overdose. Of course toddlers are known to be at high risk for accidentally poisoning as well but statistically not as many of them will die. Most infants do not have the developmental capability of overdosing as hand-and-eye coordination limits them, and teen overdose is more often intentional.

**62.** The community health nurse is asked to organize a health promotion project that plans to provide glucose screening. This activity will be most beneficial within what realm?

1. if testing is performed by volunteers at a local department store and is open to all the public
2. as a professional health fair activity available for selected persons who have been screened as being at risk
3. by mass marketing via sending out vouchers for free fingersticks at a local drugstore so the pharmacist can make recommendations on the findings
4. if testing is performed by a nurse professional and education regarding the findings given immediately

(2) Public glucose screening has been found to be an ineffective way to screen for diabetes unless based on health risk screening for those persons identified to be at risk or displaying symptoms. Therefore, it would be an error in judgment to use resources in the above manner.

**63.** Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

1. primary prevention.
2. secondary prevention.
3. tertiary prevention.
4. disability prevention.

(2) The three levels of prevention address disease and disability across all phases from absence of disease and at risk to preventing further impairment. Hearing impairment associated with prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.



**64.** A client is admitted for a lumpectomy with biopsy of a mass on the left breast. While the client is anesthetized and in surgery, the biopsy preliminary report is positive for an aggressive form of breast cancer. The surgeon had discussed this possible outcome with the client and advises the circulating nurse to notify the family that she will proceed with a mastectomy. The nurse's first response is:

1. advise the surgeon that it is his responsibility to discuss this with the family.
2. proceed with the surgeon's order and notify the family.
3. refuse to follow the order and assist further with the surgery.
4. question the surgeon reminding her of the legal ramifications of proceeding without informed consent.

(4) A doctor or any other provider may only perform a procedure on a patient who has given his informed consent. To do so otherwise, is to commit battery and possibly malpractice. Since the client is anesthetized, the proper course would be to allow her to regain consciousness and grant permission for more surgery. Presuming the family has the client's permission to be given information about the results of the biopsy, it is probably better that the physician do so, but not essential. To refuse to assist the surgeon during a surgical procedure (the nurse has engaged herself in the care of the client) could be determined by a jury to be patient abandonment.

**65.** The nurse is giving an intramuscular injection and aspirates blood. What is the next action?

1. Document an incident form.
2. Have a more experienced nurse administer the injection.
3. Withdraw the needle, measure a new dose in a new syringe, and give the medication in another site.
4. Slowly inject the medication observing the patient closely for a reaction.

(3) If blood is aspirated during an intramuscular injection, the nurse should withdraw the needle, discard and readminister a new dose of medication via a new needle. If medication is injected into the vasculature, the injection is absorbed immediately similar to an intravenous injection. Most intramuscular dosages are higher to adjust for the slower absorption time from muscle. Therefore, an intramuscular dose injected into the blood would probably be too much medication, possibly even an overdose. Reporting the event via documentation of an occurrence or incident form should occur for quality improvement purposes. Having a more experienced nurse administer the repeat injection is a possible option, but not necessary. The possibility of injecting into vessel versus muscle exists with every intramuscular injection necessitating the aspiration safeguard.

**66.** The nurse is preparing to administer IV Vancomycin to the client. Which of the following nursing actions should be taken first?

1. performing a physical assessment prior to administration
2. ensuring the client is not allergic to the medication
3. reviewing peaks and troughs for the past few days
4. obtaining the most recent lab values regarding renal function

(2) Even before the physical assessment (that may or may not be indicated at the time of administration of Vancomycin), ensuring that the client is not allergic to the medication is the most critical action the nurse must take before administering any drug. Lab values regarding renal function and therapeutic ranges via peaks and troughs are also important with some medication such as Vancomycin. Renal damage can occur if blood drug levels remain high over time.

**67.** A patient taking isotretinoin (Accutane) tells you that she is pregnant. What will the nurse teach the patient?

1. Her pregnancy is threatened, and the fetus is at risk for teratogenesis.
2. She has a reportable condition, and the pregnancy must be terminated.
3. Accutane is a category D drug that means it is unsafe in pregnancy.
4. Her pregnancy must be followed carefully by a genetic specialist.

(1) Accutane is a category X drug that means pregnancy is contraindicated due to teratogenesis associated with the medication. The pharmaceutical manufacturer should be notified of any pregnancy occurring while taking the drug, but reporting is voluntary. Choosing to terminate the pregnancy is a personal decision which requires full information. Consultation with a genetic specialist or OB doctor is indicated if the client chooses to continue the pregnancy.

**68.** When a drug is listed as Category X and prescribed to women of child-bearing age/capacity, the nurse collaboratively with the interdisciplinary team will counsel the client that:

1. pregnancy tests may be unreliable while taking the drug.
2. she must use a reliable form of birth control.
3. she should not take the Category X drug on days she has intercourse.
4. she must follow-up with an endocrinologist.

(2) Category X drugs have many practice limitations when prescribed and dispensed to women, such as the prescription is valid for 7 days only and if not filled, expires—for example, Isotretinoin (Accutane). The FDA provides a pregnancy prevention program for clients taking the drug. Prior to prescribing a category X drug, a pregnancy test should be done.

**69.** The nurse seeks to assess the renal function of an elderly client about to receive a nephrotoxic medication. Which of the following labs will provide the best indicator for renal function?

1. urinalysis
2. creatinine and blood urea nitrogen
3. chemistry of electrolytes
4. creatinine clearance

(4) Due to decreases in lean body mass, blood creatinine is not as good of an indicator of the elderly client's renal function as creatinine clearance. Urinalysis and blood urea nitrogen reflect hydration status and other clues to health but are not specific for renal function. The electrolytes may be deranged in renal failure but are not a direct correlation to the kidney's ability to eliminate waste. Therefore, the best lab for renal function in the elderly is thought to be creatinine clearance, which is a widely used test for glomerular filtration rate.

**70.** Just as the nurse administers an injection of penicillin, the client responds, "I forgot to tell you that I am allergic to penicillin." The next action of the nurse is:

1. notify the M.D. of the error.
2. document the occurrence in the incident report.
3. open the airway and establish breathing at two breaths per minute.
4. obtain a complete history quickly and assess the client's vital signs.

(4) A full history should be gathered quickly with current vital signs, the physician should be notified and the ABCs supported. After the urgency of the situation is subsided, and the patient is stabilized, an incident report should be completed for the risk manager.

**71.** A client allergic to penicillin has inadvertently received an injection intramuscularly. Based on the principles of absorption and distribution, at what time should initial signs of allergy be seen?

1. instantly
2. 20–30 minutes
3. within 1 hour
4. within 24 hours

(2) Intramuscular absorption rate is approximately 30 minutes in most clients.

**72.** When a client is allergic to a medication, the warning found in the literature to not give the drug is known as:

1. legend.
2. side effects.
3. contraindication.
4. toxicity.

(3) A drug is contraindicated when it should not be given to this patient or in this situation. Contraindications may involve individual responses or drug to drug and drug to diet interactions warnings such as not mixing alcohol with a CNS drug. A contraindication is a more severe warning than a precaution which predicts a possible ill effect. The legend drugs are prescriptions that are required by federal law to bear the statement: "Caution: Federal law prohibits the dispensing of this medication without a prescription." A side effect is an undesirable yet expected and generally a mild drug effect that accompanies normal usage while toxicity is a harmful effect of having too much drug in the blood. Toxicity can be associated with severe and even life threatening effects.

**73.** Which of the following most accurately represent an adverse effect from a drug?

1. gastrointestinal bleeding after taking a regular dose of ibuprofen
2. a contraindication to certain vaccines due to an egg allergy
3. increased clotting time after taking the prescribed dose of aspirin
4. hypotension leading to cardiac arrest after mixing sildenafil and nitroglycerine

(1) Gastrointestinal bleeding with the use of ibuprofen is the best example of an adverse drug reaction. A contraindication is a more absolute warning to not take the medicine in the presence of another specific condition or drug use, while increased clotting time is the desired and anticipated effect from low dose daily aspirin. Hypotension leading to a life-threatening cardiac event is serious drug-to-drug interaction and would also be most properly termed a contraindication.

**74.** The patient is starting treatment for bipolar disorder with Lithium. What main point will the nurse emphasize in patient education?

1. The drug has a narrow therapeutic index; therefore, careful drug monitoring by blood levels is essential.
2. The drug must not be mixed with tyramine-based foods such as aged cheese and wine.
3. The drug is absolutely contraindicated for a woman who may become pregnant.
4. The drug has the side effects of nausea, drowsiness, and itching.

(1) The drug must be monitored by blood levels because the therapeutic range and the toxic level are closely related. Lithium is a Category D drug, which means pregnancy is not advised, but the benefits to the patient may outweigh the fetal risks. Monoamine oxidase inhibitors are an old class of anti-depressants who interact with the chemical tyramine found in many foods. While the side effects noted may occur, they are not a typical side effect profile with Lithium and would not be as important as blood drug levels in patient education.

**75.** The nurse is administering tetracycline to a patient. Which of the following actions will she take?

1. The drug will be given with fruit juice.
2. The drug will be given on an empty stomach.
3. The drug will be given with a glass of milk.
4. The drug will be given to a pediatric client.

(2) The drug is given on an empty stomach to aid in absorption. It should be administered with water and is contraindicated with dairy products including milk. The drug is not used in pregnancy and in pediatrics (children under 12) due to its effect on calcium stores resulting in discoloration of teeth, damage to enamel, and bone growth retardation.

**76.** The nurse will teach the client receiving the anti-fungal, Griseofulvin, what measure to enhance absorption?

1. Do not mix with milk.
2. Take the medicine on an empty stomach.
3. Take the medicine with a high fat meal.
4. Take the medicine with alcohol.

(3) Griseofulvin's absorption is increased when taken with a fatty meal. Therefore, an empty stomach would delay absorption, and a disulfiram type reaction occurs with the combined ingestion of ethanol. Milk is typically considered high fat, but still not as desirable for absorption as ice cream.

**77.** The nurse will teach the client taking nitrates about which problem?

1. hallucinations and bad dreams
2. a metallic taste in the mouth if not taken with juice drink
3. tachyphylaxis requiring being off the drug for 8–12 hours each day
4. the need for blood level monitoring on a periodic basis to ensure the drug is in the therapeutic range

(3) Tachyphylaxis is a drug tolerance problem that develops quickly, necessitating being off the drug for at least 8 hours each day. Nitrates are not associated with a metallic taste, sleep disturbances such as hallucinations and bad dreams, nor the need for blood level monitoring.

**78.** When a client is taking more than one drug strongly bound to protein, the nurse will caution the client regarding what potential problem?

1. metabolic tolerance
2. increase side effects from all the drugs
3. toxicity
4. allergic drug response

(3) Toxicity is a greater likelihood when drugs that compete for protein binding are taken together as free drug levels may increase. Side effects may occur and can be pronounced, but this problem is not as significant as the concern of toxicity. Metabolic tolerance occurs when the body rapidly metabolizes a drug requiring higher doses and there is not a relationship to increased risk of allergy.

**79.** The client is admitted via the emergency department with a diagnosis of Morphine overdose, and intravenous Naloxone is given. The nurse understands the rationale for administering Naloxone is:

1. to agonize the Morphine effects.
2. to antagonize the effects of the Morphine.
3. to sensitize the cellular receptors and prevent further metabolism.
4. to speed elimination of the Morphine via renal metabolism.

(2) Naloxone (Narcan) is classified as an antagonist, which means that it will reverse the receptor binding; thus, the action of the Morphine at its targeted site in the central nervous system is disrupted by the displacement of the opioid by naloxone. Agonists potentiate to strengthen a drug effect. Sensitization refers to allergic response, not drug metabolism, and naloxone does not induce renal elimination. The liver metabolizes most drugs, and the kidneys eliminate.

**80.** Which of the following drugs will not require the client to have blood drug level monitoring done?

1. Lanoxin
2. Librium
3. Propranolol
4. Theophylline

(3) Propranolol (Inderal) does not require blood drug level monitoring of the therapeutic range as Lanoxin, Librium, and Theophylline do because of their narrow therapeutic index.

**81.** A client's drug order includes changing the route and dose of Propranolol from 1 mg intravenously to 10 mg intramuscularly, and the nurse understands this relates to:

1. enterohepatic circulation.
2. drug half-life principles.
3. first pass effects in the liver.
4. renal drug excretion.

(3) First pass effects in the liver may partially or completely inactivate a drug requiring the need for increased drug dosage if taken orally. Enterohepatic circulation relates to the absorption of the drug via the small intestines into the hepatic circulation at which time changes may occur by the liver followed by elimination into the bile. Plasma drug levels are affected by the drug's half-life to the extent that the half life indicates how much drug is available at a particular time. Defined as the time required for the amount of the drug in the body to decrease by 50 percent, the half-life of the drug does not change based on the amount of drug. Drugs with long half lives take longer to be eliminated. Factors affecting renal excretion are glomerular filtration, passive reabsorption, and active transport. In healthy kidneys, the dose does not need to be altered.

**82.** What nursing action would cause an inadvertent toxic dose to be administered?

1. The nurse administers an enteric-coated tablet with an antacid.
2. The nurse crushes a sustained-release tablet and administers it via the gastrostomy tube.
3. The nurse administers a suspension medication through the nasogastric tube and then flushes the tubing with clear water.
4. The nurse administers the intravenous dose of Demerol via the intramuscular route.

(2) Sustained-released drugs are formulated in higher dosages to be released over time; therefore, crushing the tablets may result in overdose.

**83.** Drug "X" has a therapeutic index of 20. The nurse knows that this indicates the drug:

1. is relatively safe to administer.
2. is unsafe to administer.
3. is prone to many drug interactions.
4. is a lethal dose.

(1) A narrow therapeutic index is more dangerous. One of 20 would be considered large or broad and more safe for the client.

**84.** Drug "X" is given IV at 10 o'clock at a dose of 60 mg. The half-life is 2 hours. At 11 o'clock, the drug will be:

1. at the minimum effective concentration.
2. in the therapeutic range.
3. at the toxic concentration range.
4. undetectable in the blood.

(2) IV administered drugs escape absorption and are rapidly distributed to the tissue. Therefore, the drug would be in the therapeutic range since it would not even be at its half-life of 2 hours.

**85.** Iatrogenic disease is defined as:

1. a disease or condition acquired because of hospitalization.
2. a disease or condition produced by medical, nursing, or other discipline's care.
3. an uncommon, unpreventable drug response linked to the client's genetic predisposition.
4. a disease or condition triggered by nosocomial exposure to infection.

(2) The Greek definition for iatrogenic, literally "disease that is physician produced" has been expanded to encompass the care delivered by all healthcare professionals including nursing. Nosocomial denotes hospital caused infection or injury, and idiosyncratic response is one that is client centered and when applied to medications, genetically predisposed.

**86.** Which of the following measures is associated with decreasing hospital clients' risk for iatrogenic harm?

1. providing a health promotion program of annual physical examinations and age-specific screenings for employees
2. requiring nursing personnel to successfully complete a medication administration test
3. requiring medical personnel to complete a guest relations/interpersonal communication training program
4. requiring pharmacists to become specialized in their respective areas of care

(2) Medication errors lead to thousands of deaths and injuries annually. Although all the factors described might improve the healthcare system, requiring nursing personnel to pass a medication administration test, thereby establishing a process for the identification of unsafe medication administration practices, most directly decreases risk of client injury. Although nursing does not account for all errors, nurses are the last line of defense between the medication and the patient.

**87.** Which of the following actions assures the client that care is being provided by a competent professional?

1. a copy of the nurse's license in plain view at the nurses' station
2. the original nursing license being worn on the nurse's person at all times
3. a plaque posting the JCAHOA accreditation in the main lobby of the hospital
4. the nurse's wearing of a photo-identification with the title of RN displayed

(4) The most effective means to ensure consumer safety of nursing care is the proper identification of the caregiver, in this situation, the nurse. Although all of the measures are correct, the identification of the properly credentialed registered nurse most directly influences the client.

**88.** Several passengers aboard an airliner suddenly become weak, suffer difficulty breathing, and collapse. The differential diagnosis is highly suspicious for:

1. outbreak of Asian flu.
2. chemical act of terror.
3. bacterial pneumonia.
4. allergic reaction.

(2) The most likely cause of groups of individuals suddenly experiencing similar signs of illness all at once is chemical exposure. Given recent history, the setting of an airliner is highly suspicious for warfare.

**89.** A child presents to the clinic with a skin rash and low-grade temperature. The lesions are widely distributed on the extremities distally, maculopapular and oozing a honey-colored liquid and are in different stages of healing. The caregiver states that the sores are getting worse and seem to spread with the child's scratching. Which of the following advisory comments will be given?

1. The history and presentation indicates chicken pox, a highly contagious disease.
2. The lesions may indicate a contagious infection that will require isolation.
3. The history and presentation may indicate a infectious illness called impetigo.
4. The lesions are not contagious unless others have open wounds or lesions themselves.

(3) The scenario describes classic impetigo, which will likely be initially treated empirically with antibiotics known effective (Penicillin, Cephalosporin). Chicken pox is highly contagious but presents with a history of high fever followed by a vesicular rash. The proper procedure for preventing spread of impetigo is generally 24 hours of isolation (out of school) and then continued contact precautions as long as blood/body fluids are present. Gloves would be indicated as well as good hand hygiene.

**90.** The nurse is teaching the client about Rifampin for prophylaxis against an exposure to meningitis. What change in bodily functions will he advise?

1. "Your urine will turn blue."
2. "You will remain infectious to others for 48 hours."
3. "Your contacts may be stained orange."
4. "Your skin may take on a crimson glow."

(3) Rifampin has the unusual effect of turning body fluids an orange color. Soft lenses may become permanently stained, and clients should of course be taught to look for these changes so that they will not be alarmed unnecessarily.

**91.** The client with HIV is being treated for oral irritation characterized by patchy areas of white plaques. He asks the nurse whether these lesions are contagious to his partner. The nurse teaches the client that:

1. HIV viral infection is transmitted by blood/body fluids contact.
2. the lesions are not contagious to others.
3. the lesions are contagious only if transmitted sexually.
4. a culture of the plaque will be taken and then the client will know for sure.

(1) Although the presentation sounds more like AIDS and an opportunistic infection (probably Candida), the best advice to the client is how to avoid transmitting HIV infection. Further, when an HIV infected person develops opportunistic infections, they are considered diagnosed with AIDS—a more serious condition—and should avoid contacts with others that will pose a risk to them in their immunocompromised state in addition to considering how they may be infectious to others.

**92.** To determine the stage of infection of HIV/AIDS, what laboratory tests are taken?

1. Elisa
2. CD4, HIV load
3. Polymerase Chain Reaction (PCR)
4. Hepatitis, PPD

(2) The two main markers for staging HIV infection and AIDS are the CD4 and HIV viral copies. These markers are typically inversely proportionate to each other. HIV infection may be initially determined most inexpensively by the Elisa test and then confirmed by Western Blot. Hepatitis and PPD testing to determine other infections might be done after staging to ensure that other co-morbidity is not present.

**93.** A stool culture reveals “Shigella.” The nurse recognizes what corollaries regarding this bacterial infection?

1. Persons who have been in contact with the client will need to be tested.
2. Shigella is an airborne infection.
3. Shigella is a bacteria sometimes found in stagnate water.
4. The nurse will wear a one-way breathing apparatus when giving patient care.

(2) Shigella is a gram negative rod in the bacteria family of Enterobacteriaceae. Transmission of Shigella is typically oral-fecal so that good hand washing and the use of gloves are the best means of prevention when caring for the client. The bacteria may be found in food and water contaminated by fecal material. Incidences of Shigella are reportable in many states.

**94.** The client on floxacin must be alerted to which of the following adverse effects?

1. stunting of height in teens and young adults
2. propensity of anovulatory uterine bleeding
3. intractable diarrhea
4. tendon rupture

(4) Floxin is a quinolone antibiotic used in respiratory infections and pelvic and reproductive infections. Rarely, quinolones can cause tendon sheath rupture, usually of the Achilles. At the first indication of tendon pain, the antibiotic should be discontinued.

**95.** Serum Vancomycin levels are taken to measure which of the following?

1. renal function
2. therapeutic range
3. trough levels
4. antibiotic resistance

(2) Vancomycin levels are monitored to ensure therapeutic effects by peak level. Trough level is that level of wash out or lowest level of drug just prior to the next dose. The blood is taken approximately two hours after an IV infusion. Renal function is measured by creatinine and BUN or creatinine clearance and resistance by sensitivity. All of the parameters are considered in the overall goals of ensuring a therapeutic pharmacologic response and avoidance of nephrotoxic adverse effects.

**96.** Which agency is responsible for laws mandating the reporting of certain infections and diseases?

1. Center for Disease Control (CDC)
2. individual state laws
3. National Institute of Health Research (NIH)
4. Health and Human Services (HHS)

(2) Individual state laws mandate the reporting of infectious diseases. The list of reportable diseases varies from state to state and is overseen by state health departments. CDC reporting is voluntary and done via collaboration with state agencies. There are 58 emerging infectious diseases under surveillance by CDC.

**97.** Several members of a local church arrive at the local ER complaining of abdominal cramping, diarrhea, and high fever. The onset of symptoms began two days after a congregational picnic. The nurse explains that what treatment is needed?

1. Stool cultures will be needed from every person suffering symptoms.
2. Hospitalization may be required for those who are severely ill.
3. All persons will require hospitalization and IV antibiotic therapy.
4. Care will be supportive, and no one will require hospitalization or antibiotics.



(2) Dehydration is often a sequelae of salmonella poisoning and may require hospitalization and rehydration. Each person will require medical examination and probably multiple antibiotic therapy. The offending infection may be identified by stool culture but in a case such as this, it may not require all persons to be tested. Since the history is easily traced to a particular gathering involving the sharing of food, the judicious use of medical services would not require all clients to have full-scale work-ups but on a need by need basis.

**98.** The client is suffering from a severe adverse drug effect associated with the use of antibiotics manifested by intractable diarrhea. The client asks what causes the problem, and the nurse will explain what?

1. an overgrowth of *E. Coli*
2. a bacteria known as *Shigella*
3. an overgrowth of *Candida*
4. a bacteria known as *Clostridium difficile*

(4) The causative agent of antibiotic associated colitis is *Clostridium difficile*. Rehydration, supportive care, and antibiotic therapy with an antibiotic such as Metronidazole or Vancomycin is indicated.

**99.** A female client intends to be treated with Isotretinoin (Accutane). What will the nurse explain to the client?

1. This is a category X medication indicating teratogenesis is probable.
2. This medication is a nuclear isotope and emits radioactive substances.
3. This medication has a narrow therapeutic index and can not be mixed with any other medication.
4. This medication will lower the immune response, making you and the fetus at risk for opportunistic infections.

(1) Isotretinoin is a teratogenic medication that is not prescribed to a child-bearing female without informed consent and proof of non-pregnancy. Women receiving the medication who are of child-bearing age must be counseled to use a reliable form of birth control as gross deformities have been linked with the use of the medication.

**100.** Epidemiology is best defined as:

1. the number of cases of illness and the percentage of a specific population affected.
2. the study of the distribution of health and determinants of diseases and injuries in human populations.
3. the study of the etiology of the disease.
4. the study of the relationship between prepathogenesis and pathological states.

(2) Epidemiology encompasses more than the etiology of disease, but the distribution of health and specific determinants increase the incidence and impact the prevalence of disease in human populations. Further, the stages of epidemiology include pre-pathogenesis to the signs and symptoms of clinical pathology.

**101.** Which of the following rationales will the nurse give for explaining to the elderly client his need of tetanus immunoglobulin with treatment of a puncture wound?

1. Herd immunity has virtually eradicated the need for tetanus immunoglobulin among the elderly.
2. Many elderly were not immunized and do not have sufficient antibodies against tetanus.
3. Tetanus toxoid is not effective in providing protection against tetanus.
4. Prophylactic antibiotics may be given to prevent infection instead of immunization.

(2) Tetanus immune globulin is needed in persons not previously immunized against tetanus. Tetanus toxoid is indicated as a booster after antibodies have been produced. Antibiotics given prophylactically will not ensure eradication of the tetanus bacillus.

Herd immunity, a condition that occurs when the population at large has been exposed and built antibodies to a certain disease does not exist for tetanus, and each year persons die needlessly from lack of protection against the infectious disease.

**102.** A sexually active teen with a yellow vaginal discharge comes to the clinic for birth control. The nurse documents information obtained from the HEADSS risk assessment, which is positive for multiple sexual partners, use of alcohol, and street drugs. In addition to documenting the information obtained from the client's history, the nurse will advise the client that she will be screened for:

1. pregnancy.
2. STD.
3. HIV.
4. all of the above.

(4) All of the above are indicated markers to assess via the HEADSS tool. The HEADSS tool is an acronym for Home/Education-School/Activities of interest/Drugs, Driving, Depression/Sex, Suicide and is a memory aid for the client's risk assessment. Note that the emotional markers were not addressed nor the substance use.

**103.** Someone who has received a recent tattoo should be screened for:

1. tuberculosis.
2. HIV.
3. Hepatitis C.
4. Syphilis.

(3) Hepatitis B and C are associated with tattooing. It is possible, but not as probable that HIV could be transmitted via the needle if sterile technique is not followed. Many tattoo parlors share ink wells with customers, and this is the source of transmission of blood-borne pathogens. Syphilis can also be transmitted by blood-borne routes but would be unlikely due to the larger sized bacterium.

**104.** Which of the following is a contraindication to the administration of immunizations that the nurse would document and discuss with the prescriber?

1. fever
2. diagnosed seizure disorder
3. anaphylaxis
4. cough

(3) The only absolute contraindicated noted here is anaphylaxis. All other signs and/or symptoms of illness would not rule out vaccination. The history of seizures, not an absolute contraindication but one that would cause the clinician to review the history and ascertain the risk:benefit ratio of giving the vaccine. All of the symptoms would be documented.

**105.** Which of the following is another name for *Yersinia pestis*?

1. Pneumonic Plague
2. Smallpox
3. Tularemia
4. Viral Hemorrhagic Fever

(1) Pneumonic plague is scientifically known as *Yersinia pestis*. Tularemia is also known as rabbit or deer fever and sometimes referred to as a plague like disease. It is caused by rodents and ticks that are blood sucking and can be transmitted by contaminated food. Smallpox is a viral, febrile illness sometimes confused with chicken pox that presents with similar symptoms and a rash. Viral hemorrhagic fevers (VHFs) are a group of infectious illnesses linked to bioterrorism. A characteristic clinical feature of VHF beyond the prodrome is bleeding even to the degree of disseminated intravascular clotting.

**106.** Which, if any, of the following is the antidote for ricin poisoning?

1. Atropine.
2. Epinephrine.
3. High-dose steroids.
4. There is no antidote for ricin at the present time.

(4) There is no antidote known for ricin poisoning, a biotoxin produced from the castor bean plant that causes the protein synthesis disturbances resulting in respiratory, GI, and blood-related clinical signs dependent on the route of administration of the toxin. Death can occur, and treatment is supportive.

**107.** The nurse's hand becomes soiled with urine while caring for a client receiving a radioactive isotope, what is the correct action?

1. Document the occurrence on an incident report.
2. Notify the infection control nurse.
3. Wash both hands liberally with soap and water.
4. Wash both hands liberally with antiseptic gel.

(3) Soiling of intact skin by body fluids requires soap and water scrub. Although the use of antiseptic cleansing gels have been shown to be effective for routine cleaning, after the hands are soiled, vigorous rubbing with soap is the best course of action to remove microbes. Generally, the infection control nurse should not be notified nor should an incident report be completed in this situation unless the nurse has open lesions on her hands that could pose an easy entry of HIV, Hep B, and other blood-borne pathogens.

**108.** The nurse is teaching a disaster preparedness class to healthcare workers. Which of the following infectious diseases is suspected as a probable biological weapon?

1. Varicella (Chicken pox)
2. Clostridium botulinum (Botulism)
3. Haemophilus influenzae (flu)
4. West Nile Virus (WNV)

(2) Clostridium botulinum has been used in biological acts of terror and is a possible form of warfare. At the present time, the other pathogens have not been associated with bioterrorism.

**109.** Which of the following responses most fully answers a mother's question, "Why should I immunize my child against measles?"

1. to prevent infections that could re-emerge
2. to prevent outbreaks in schools and communities
3. to protect your child from a disease common in other parts of the world and one that could occur in the United States
4. a lot of people stopped immunizing in the 80s and 90s and more than a hundred kids died

(3) The response that immunizations protect against potential diseases that may occur in the United States is the most relevant, best answer. All of the responses are correct, however, 1 and 2 are not specific to the client, and 4 is blaming in nature and should be avoided.

**110.** Which of the following statements is incorrect about why DTaP is felt to be the superior form of immunization today?

1. It can be combined with more vaccinations reducing the need of multiple injections.
2. DTaP has a safer side effect profile than the DTP.
3. Studies indicate that it confers equal pertussis immunization as the DTP when administered correctly.
4. Many available forms are on the market, and they can all be used interchangeably for all five initial doses.

(4) Several choices in the immunizations arena are not available. The research and development of even one vaccine is expensive and lengthy. Further, the immunizations may only be given together if outlined by guidelines such as the CDC's Advisory Council on Immunization Practice(ACIP) and must be given only under the umbrella of a prescriber's directive.

**111.** Which statement about varicella vaccine is correct?

1. The varicella zoster virus is mildly contagious.
2. The risk for complications from chickenpox is highest for school-aged children and young adolescents.
3. The vaccination can be safely administered in pregnancy.
4. Adults who experience the illness are at high risk for serious sequelae such as pneumonia and secondary infection.

(4) The varicella virus is highly contagious, and persons at risk for the disease should be separated from any person suspected of being contagious. The vaccination cannot be safely administered in pregnancy (as it is a live virus) nor is the disease more severe in older children and teens. Adults and the elderly typically are at greatest risk for serious illness requiring hospitalization in many cases.

**112.** A 30-month-old child comes to the clinic for preschool immunizations.

Immunizations are documented up to date with the exception of varicella and MMR. Unless contraindicated, the nurse will administer:

1. the varicella, but not the MMR.
2. defer the varicella and the MMR.
3. have child return when age 6 years.
4. give the immunizations.

(4) The child should receive both immunizations unless he is allergic or immuno-compromised. The risks of illness and deaths are much greater than the risks of side effects from the vaccines.

**113.** You are preparing to immunize a 36-month-old child with Pneumococcal Conjugate Vaccine (PCV) who had one dose only of PCV at 23 months. Recommendations for immunization are:

1. 1 dose of PCV.
2. 2 doses of PCV at least 2 months apart.
3. 2 doses of PCV 6 months apart.
4. no further immunization.

(1) The Advisory Committee on Immunizations Practices (ACIP) recommends that two doses of the vaccine be given up until the age of 2 years and then the decision is guided by other factors such as degree of risk. Since the child in this scenario was under two years and received only one dose, another dose is indicated.

**114.** A child received an MMR at age 11 months and 2 weeks. At the 15-month check up the nurse notes that besides the MMR, he has received no immunizations since age 4 months. To “catch up,” the nurse will most likely administer:

1. MMR only.
2. DtaP, PCV7, IPV, and Hep B.
3. DtaP, Hib, PCV7, IPV, IV, MMR, VZ, and Hep B .
4. Dtap, Hib, PCV 7, IPV, VZ, and Hep B.

Abbreviations: DtaP—Diphtheria, tetanus toxoid, acellular pertussis, Hib—Haemophilus influenza Type b, Hep—Hepatitis (A or B), IPV—Inactivated Polio, IV—Influenza

(3) Today’s visit indicates a golden opportunity to “catch-up” on the immunizations for the child. Therefore, he should receive all the remaining vaccinations due in his age group unless there is a contraindication.

**115.** The nurse knows the microbiology of Anthrax includes which of the following?

1. The anthrax virus is highly contagious.
2. The pathogen mainly produces neurological and hematologic signs of poisoning.
3. There is no postexposure prophylaxis recommendation.
4. The anthrax microbe is an aerobic, gram positive bacillus.

(4) Bacillus anthracis is a gram positive, aerobic microorganism that is responsive to antibiotic treatment. Treatment including prophylaxis should begin at the earliest possible time post exposure. There are many manifestations of anthrax infection, but primarily respiratory and cutaneous signs are the strongest clinical markers. Anthrax is transmitted via spores that find their way to the lungs where incubation occurs. It is not transmitted by person-to-person contact, but contact with the spores that produce toxins in the host.

**116.** What immunizations are commonly recommended for the over 65 age group?

1. Hib (Haemophilus influenzae Type b), influenza (flu), PCV (pneumococcal)
2. Varicella (chicken pox)
3. Hep A (Hepatitis), MMR (Measles, Mumps, Rubella), DPT (Diphtheria, Pertussis, Tetanus)
4. Td (Tetanus toxoid), pneumococcal, influenza

(4) The Td, pneumococcal, and influenza immunizations are indicated for the older age group. The remainder of the vaccines apply to childhood illness prevention with the exception of Hepatitis, and vaccination against Hepatitis A in the elderly would be determined based on a risk:benefit ratio only in cases of an endemic outbreak.

**117.** A client has an abdominal infection. What is the first indication of the course of the infection?

1. There are no longer any acute symptoms.
2. The client was first exposed to the infections two days ago but has no symptoms.
3. An oral temperature reveals a very febrile condition.
4. The client feels sick but is able to continue her normal activities.

(3) The temperature taken at least every four hours can reveal a change in the body due to the infection process.

**118.** An example of sterile asepsis is:

1. giving an intramuscular injection.
2. getting gloves from the open box in the client’s room.
3. using clean forceps on a sterile field.
4. hand washing.

(1) The needle and technique of drawing the medication into the syringe should be sterile technique for giving the intramuscular injection.

**119.** The nurse is aware that which of the following conditions would be treated with antibiotics?

1. Chlamydia trachomatis
2. Varicella
3. Herpes Simplex
4. Epstein-Barr infection

(1) Chlamydia is a sexually transmitted infection caused by the microorganism, *Chlamydia trachomatis*, which should be treated with antibiotics such as “mycins” or Doxycycline. Varicella (Herpes Zoster) and Herpes Simplex (cold sores, some genital ulcers) and Epstein-Barr infections such as mononucleosis are all viral infections and do not typically warrant antibiotic therapy.

**120.** The nurse teaching the client about acquired immunity will explain that it results from which of the following?

1. Antigens are artificially introduced by vaccine into the body with resulting antibody production.
2. Antibodies produced from another source such as an animal or another human are introduced into the body.
3. The antibodies are formed in the client’s body and give lifelong immunity.
4. Antibody production occurs in response to an active infection in the client.

(2) In acquired or passive immunity, the client takes antibodies produced by another source (maternal-fetal) or immune serum. Acquired immunity is of short duration.

**121.** Which of the following nursing interventions demonstrates surgical asepsis versus medical asepsis?

1. The nurse applies sterile drapes to create a field during urinary catheterization.
2. The nurse wears gloves prior to performing tracheal suctioning.
3. The nurse performs a hand washing scrub before and after an invasive procedure.
4. The nurse wears personal protection such as goggles and gown during a sterile dressing change.

(1) Protecting an area from the invasion of microbes is consistent with sterile asepsis, while all the other nursing interventions would not necessary prevent microbial invasion—only limit its extent.

**122.** The nurse teaching a class on hygiene who explains how a certain microorganism is normal in the intestines yet produces infection in other body systems such as the blood and urine is discussing which microbe?

1. *Streptococcus epidermis*
2. *Candida albicans*
3. *Staphylococcus aureus*
4. *Escherichia coli*

(4) The large bowel is normally inhabited by *Escherichia coli* (E coli), which is engaged in the breakdown of waste. *Streptococcus epidermis* is resident on the skin while *Candida albicans* is found in the vagina, and *Staphylococcus aureus* is resident of the nasal and throat passages.

**123.** The post-operative wound is infected with *Pseudomonas aeruginosa*. If the patient’s vital signs include T:101.4, P: 120, R 40, B/P: 84/60 and the CBC includes a wbc of 12,000, the nurse will conclude:

1. the clinical markers represent the signs of a localized infection.
2. the clinical markers represent the signs of viremia superimposed onto a surgical infection.
3. the clinical markers represent the signs of chronic infection.
4. the clinical markers represent the signs of systemic infection.

(4) When a local infection invades other body systems, a systemic infection exists. Although signs of localized infection include inflammation, local tenderness, low-grade temperature or no temperature increase, the signs of systemic infection are more serious and include vital signs changes such as increased temperature, tachycardia, tachypnea, and B/P changes. In this scenario, the vital signs may indicate impending septic shock an extreme, life-threatening clinical

presentation. A chronic infection does not typically produce major changes in normal vital signs such as hypotension and high fevers. The wbc is not elevated in viral states. It should be noted that if the patient is immunocompromised, vital sign changes and wbc might not be dramatic so a high index of suspicion must exist for any such patient manifesting even subtle signs of infection. Further lab studies such as a blood culture are needed to confirm the systemic infection (bacteremia).

**124.** When a patient tests positive on culture for *Pseudomonas aeruginosa* of the surgical wound, the etiology is probably:

1. cross contamination.
2. nosocomial.
3. inadequate hand washing.
4. incorrect dressing technique.

(2) Nosocomial infections are hospital acquired and are presumed induced via the consumption of healthcare. Since cross contamination, inadequate hand washing, and improper dressing technique are all examples of health provider caused, nosocomial infections is the overall correct response.

**125.** The nurse is reviewing the laboratory results from a wound culture and notes that the infection is sensitive to erythromycin, levofloxacin, and cephalosporin. If the patient is allergic to “mycin” antibiotics, she might anticipate which of the following antibiotic classification in the medication order?

1. Augmentin
2. Gentamicin
3. Levaquin
4. Pediazole

(3) Based on the sensitivity to levofloxacin, a macrolide, the client will be given Levaquin. Augmentin is in the class of beta lactam penicillins, and there is no cephalosporin option given. The client is allergic to erythromycin so could not receive Pediazole, which is a combined erythromycin and sulfa antibiotic.

**126.** Which of the following antibiotics is indicated for a post-operative surgical wound infection positive for staphylococcus?

1. Tetracycline (TCN)
2. Amoxicillin (Amoxil)
3. Sulfa
4. Cefoxitin (Mefoxin)

(4) Cefoxitin is an excellent choice of antibiotic for peritoneal wound infections.

**127.** A term newborn is suspected of sepsis. Even if the offending organism is not identified, what is the likely course of action?

1. The infant will have blood, urine, and fecal cultures taken and be observed for 48 hours.
2. The infant will be given Ampicillin (75 mg/kg/dose)—IV/IM twice a day.
3. The infant will be given Amoxicillin (80mg/kg/dose)—orally twice a day.
4. The infant will be given Tetracycline 250 mg IM four times a day.

(2) The infant will be treated for sepsis while awaiting blood culture reports.

**128.** After 48 hours of observation and care in the NICU, a neonate's blood cultures are not growing any pathogens; what will the next course of action be?

1. Antibiotics will be continued prophylactically for 7 days.
2. Antibiotics will be discontinued.
3. The neonate will be discharged.
4. The mother may resume breastfeeding.

(2) After 48 hours, if blood cultures are negative, antibiotics will be discontinued. Depending on the vital signs and overall health of the neonate, other interventions may include discharge home. Breastfeeding should not have been interrupted because of suspected sepsis unless there was another problem not given in the facts. For infants in this situation, a hearing screening should be done if gentamicin was administered.

**129.** A green, purulent discharge accompanied by a putrid odor is found on the initial dressing change of an exploratory laparotomy secondary to a gunshot wound to the upper abdomen. The nurse suspects which of the following organisms?

1. *Propionibacterium acnes*
2. *Proteus*
3. *Enterobacteriaceae*
4. *Lactobacillus*

(3) An enterobacteriod is the most likely source of infection from the options given for this “dirty” wound. *Proteus* and *lactobacilli* are most commonly found in the genito-urethral areas, and *propionibacterium acnes* is found on the skin.

**130.** The nurse is caring for a postoperative client with a temperature of 103.6°F. After collecting a blood specimen for a culture, which of the following will most likely be ordered by the client's physician?

1. gram-positive
2. gram-negative
3. antifungal
4. broad-spectrum

(4) Broad-spectrum antibiotics should be started either per intravenous solution or intramuscular. The nurse should take all vital signs and continue this process at regular intervals. Allergy to medications should be assessed as well as possible conditions or other medications that might cause a problem with the antibiotics. Comfort measures—bed position, measures to add comfort from the temperature, fluids (oral) if not on anything by mouth.

**131.** A client is seen in the emergency room following an indoor party and was diagnosed with Tuberculosis. The nurse should explain to the client that this type of infection is transmitted in which of the following ways?

1. vehicle
2. vector
3. airborne
4. direct contact

(3) Tuberculosis is an airborne organism and can be obtained by being exposed to the microorganisms through the air—especially in closed areas. This usually is manifested in the respiratory system; symptoms include vomiting blood, vague chest pain, night sweats, dyspnea. The bacillus is generally sensitive to isoniazid (INH), paraaminosalicylic acid, streptomycin, rifampin, others (combination of drugs is prescribed). Nursing intervention should include: medication, aseptic technique, nutrition, danger symptoms, multiple teaching.



**132.** The nurse has instructed a group of healthcare workers about prevention of the virus that transmits hepatitis B. The nurse determines that one of the workers needs further instructions when she says that the virus is transmitted by:

1. blood.
2. feces.
3. bodily fluids.
4. sputum.

(4) Hepatitis B is usually majorly transmitted by body fluids, needle sticks, or blood. Precautions should be taken to hinder this disease. These precautions include: wearing appropriate clothing; special glasses; gloves while doing special procedures; any “sharps” should be placed in a hazard container; above all hand washing always.

**133.** A client is hospitalized with a urinary tract infection. The client needs a “Foley” (indwelling) catheter in place. The nurse is responsible for doing this procedure. What precautions need to be used?

1. Utilize a set that has been opened.
2. Utilize a sterile set.
3. Utilize an aseptic set.
4. It doesn't matter just so the catheter is in place.

(2) In putting a “Foley” (indwelling) catheter in the urinary bladder, the nurse should use all precautions of sterility so as not to increase the patients infection, which can ascend to the ureters and eventually the kidneys.

**134.** A 30-year-old client is preparing for discharge from the hospital when the client develops a temperature of 102.8°F. The nurse determines that the client is experiencing an infection termed:

1. nosocomial.
2. extracorporeal.
3. incidental.
4. resistant

(1) Nosocomial infections are classified as infections that are associated with the delivery of healthcare services in a healthcare facility. Nosocomial infections can either develop during a client's stay in a facility or manifest after discharge. Nosocomial microorganisms (for example, tuberculosis and HIV) may also be acquired by health personnel working in the facility and can cause significant illness and time lost from work. The hands of personnel are a common vehicle for the spread of microorganisms. Insufficient hand washing is thus an important factor contributing to the spread of nosocomial microorganisms.

**135.** A 70-year-old client has had an indwelling urinary catheter for 2 days following surgery. Before removing the catheter, the nurse sends a urine sample for analysis, culture, and sensitivity to determine whether the client has developed an infection termed:

1. endogenous.
2. viral.
3. microbial.
4. iatrogenic.

(4) Iatrogenic disease is a disease caused unintentionally by medical therapy. A number of factors contribute to nosocomial infections (infections associated with delivery of healthcare in a healthcare facility). Iatrogenic infections are the direct result of diagnostic or therapeutic procedures. One example of an iatrogenic infection is bacteremia that results from an intravascular line. Not all nosocomial infections are iatrogenic, nor are all nosocomial infections preventable.

**136.** The nurse has conducted a class for healthcare workers on the topic of infection control. The nurse determines that one of the workers needs further instructions when he says:

1. "Most hospital-acquired infections are due to bacteria."
2. "Indwelling catheters have been implicated in a large percentage of infections."
3. "Hospital-acquired infections are relatively easy to treat with antibiotics."
4. "Frequent hand-washing is the best method of preventing hospital-acquired infections."

(3) Reports from the National Nosocomial Infection surveillance System have revealed that the urinary tract, the respiratory tract, bloodstream, and wounds are the most common nosocomial infection sites. The cost of nosocomial infections to the client, the facility, and funding sources (for example, insurance companies and federal, state, or local governments) is great. Nosocomial infections extend hospitalization time, increase clients' time away from work, cause disability and discomfort, and even result in loss of life.

**137.** The nurse observed that the healthcare workers on a ward are using medical asepsis if they (all except):

1. keep soiled linens away from her clothing.
2. place soiled linens on the floor near the client.
3. use a dampened cloth to dust the bedside table.
4. clean the bed (soiled) with gloves.

(2) Medical asepsis includes all practices intended to confine a specific microorganisms to a specific area, limiting the number, growth, and transmission of microorganisms. In medical asepsis, objects are referred to as clean, which means the absence of almost all microorganisms, or dirty (soiled, contaminated), which means likely to have microorganisms, some of which may be capable of causing infection. Placing soiled linens on the floor near the client is not aseptic technique.

**138.** Before changing a clean dressing of a home care client, the nurse should first:

1. wash the hands with an antibacterial soap.
2. remove any nail polish on the fingernails.
3. put on two pairs of clean gloves.
4. remove any wedding rings or other jewelry.

(1) The hands of the healthcare personnel are common vehicles for the spread of microorganisms. Insufficient hand washing is thus an important factor contributing to the spread of nosocomial microorganisms. For routine client care, the CDC recommends antimicrobial foam, hand gel, or vigorous hand washing under a stream of water for at least 10 seconds using granule soap, soap-filled sheets, or antimicrobial liquid soap. Antimicrobial soaps are usually provided in high-risk areas, such as the newborn nursery and are frequently supplied in dispensers at the sink. Studies have shown that the convenience of antimicrobial foams and gels, which require soap and water, may increase healthcare worker's adherence to hand cleansing. The CDC recommends antimicrobial hand washing agents in the following situations: when there are known multiple resistant bacteria, before invasive procedures, in special care units, such as nurseries and ICUs, and before caring for severely immunocompromised clients.

**139.** The nurse assesses a sterile field in the delivery room that has been contaminated when the nurse observes:

1. the outer 1 inch of the sterile towel over the side of the table.
2. sterile objects held above the waist of the practitioner.
3. sterile packages opened so that the first edge is away from the practitioner.
4. wetness on the sterile cloth on top of a non-sterile table.

(4) The nurse must be knowledgeable about sources and modes of transmission of microorganisms. A sterile field is a microorganism free area. Moisture that passes through a sterile object draws microorganisms from unsterile surfaces above or below to the sterile surface by capillary action.

**140.** Instruction should be given by the nurse, concerning universal precautions when handling patient items that are dirty (soiled). Which of the following is not considered dirty (soiled)?

1. amniotic fluid
2. vaginal secretions
3. blood Pathogens
4. saline

(4) Saline is a solution, not a body fluid. Universal precautions are techniques to be used with all clients to decrease the risk of transmitting unidentified pathogens.

**141.** A nurse is caring for a client with an open wound needs to change the dressing with:

1. clean technique.
2. antiseptic technique.
3. sterile technique.
4. medical technique.

(3) Open wounds provide an entry to invasion of microorganisms; thus, a sterile procedure should be carried out. Hand washing is a must!

**142.** The nurse is taking care of a client with tuberculosis needs to wear:

1. masks.
2. sterile gloves.
3. clean gowns.
4. sterile gowns.

(1) Tuberculosis is an airborne bacteria infection (mycobacterium tuberculosis). The droplets from the tuberculosis can be transmitted by the client to healthcare workers; thus, masks are of great importance.

**143.** An infection control nurse becomes concerned when she observes:

1. needles put into a hazard container.
2. gloves being worn by housekeeping staff.
3. blood dried under the client's mattress and bed.
4. carrying double-bagged soiled linen.

(3) Any blood, specimen(s) from the client, soiled client's bedclothes and linen, or other contaminated materials should be under Universal Precautions.

**144.** While caring for a client who has intermittent diarrhea, the nurse plans to take precautions to prevent contamination from:

1. *Escherichia coli*.
2. *Clostridium difficile*.
3. *Staphylococcus aureus*.
4. *Neisseria meningitidis*.

(1) The microorganism, *Escherichia coli* is from feces (rectum); dust particles containing the infectious agent, *clostridium difficile*, are spores from the soil that become airborne. These spores are transmitted by air currents to a suitable portal of entry, usually the respiratory tract, of another person; *staphylococcus aureus*—a species frequently responsible for abscesses, endocarditis, impetigo, osteomyelitis, pneumonia and septicemia; *neisseria meningitidis*—or any infection or inflammation of the membranes covering the brain and spinal cord; this is one of the most common.

**145.** The nurse has demonstrated how to put on sterile gloves to a group of nursing students. The nurse should instruct the students that:

1. vinyl glove punctures reseal automatically.
2. latex gloves are used primarily with minor procedures.
3. vinyl gloves are less costly and easier to put on.
4. latex gloves can result in allergic reactions.

(4) Nurses need to know that there are individuals who have allergic responses to natural latex rubber products.

**146.** The nurse is teaching a teenage female about preventing the transmission of genital herpes. Which of the following statements will be advised?

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

(3) Genital Herpes can be transmitted by sexual contact—both oral and genital, including anal. The other statements are myths.

**147.** A patient is diagnosed with HIV. Which of the following are anti-viral drug classes used in the treatment of HIV/AIDS?

1. Nucleoside Reverse Transcriptase Inhibitors
2. Protease Inhibitors
3. HIV Fusion Inhibitors
4. all of the above

(4) All of the following options are anti-HIV drugs used in therapy.

**148.** Someone who has received a recent tattoo should be screened for:

1. Tuberculosis.
2. Herpes.
3. Hepatitis.
4. Syphilis.

(3) Commercial tattooing might put the client at risk for blood borne Hepatitis B or C if strict sterile procedures are not followed. A common practice in some parlors is to use a single inkwell, needle dipped multiple times for more than one patron. Tuberculosis is an airborne pathogen while Herpes and Syphilis are spread directly such as in sexual contact.

**149.** The orientation nurse educator reviewing the biohazard legend with a class of new employees states that the emblem is affixed to containers whenever:

1. there is handling of blood and body fluids.
2. there is the need for droplet precaution.
3. there is contact isolation.
4. there is the potential for airborne transmission.

(1) When body substances are handled, the potential for transmission is increased; therefore, federal regulations require warning labels to communicate with other employees and/or waste collectors. The biohazard alert is a 3-ring symbol overlaying a central concentric ring. Blood, drainage from wounds, feces, and urine are all body fluids that may transfer infection and disease to others.

**150.** The emergency triage nurse will perform which action upon receiving the history that the client has a severe cough, fever, night sweats, and body wasting?

1. Place the client in the waiting room until an available cubicle is open.
2. Seclude the client from other clients and visitors.
3. Take no intervention because it may not be necessary until tests confirm a disease.
4. Don gown, gloves and mask immediately.

(2) The client is describing signs and symptoms of tuberculosis. The client is potentially infectious to others and should be secluded. A “respirator mask” should be worn by caregivers, but it is not necessary for the nurse to gown and glove. If the client is moved to other areas such as radiology, a mask should be worn by the client and a “respirator mask” by those working in close contact of the client.

**151.** Which of the following clients will require airborne precautions?

1. a client with fever, chills, vomiting, and diarrhea
2. a client suspected of varicella (chicken pox)
3. a client with abdominal pain and purpura
4. a client diagnosed with AIDS

(2) Chicken pox (Varicella) is an acute, infectious airborne illness that requires others in direct contact to wear a “respirator,” a special face mask.

**152.** The nurse sustains a needle puncture that requires HIV prophylaxis, which of the medication regimens will be used?

1. an antibiotic such as Metronidazole and a Protease inhibitor (for example, Saquinivir)
2. two Non-nucleoside Reverse Transcriptase inhibitors
3. one Protease inhibitor such as Nelfinavir
4. two Protease inhibitors

(2) Unless there is drug resistance, the initial prophylaxis based on CDC recommendations is 2 NNRTIs. Metronidazole is an anti-fungal and anti-protozoal antibacterial agent.

**153.** A patient is taking the fluoroquinolone, Ciprofloxacin, for acute prostatitis. After a few dosages of the agent, he develops severe muscle pain. The most likely cause of the adverse reaction is:

1. electrolyte imbalance.
2. impending tendon rupture.
3. calcium deposits.
4. antibiotic associated colitis.

(2) An untoward, adverse drug reaction associated with the quinolone drug group is tendon rupture. Electrolyte imbalance has not been associated with the group, and antibiotic-associated colitis is most common in Clindamycin, augmentin and other penicillin groups.

**154.** Acyclovir (Zovirax) is the agent of choice for which of the following infections?

1. HIV
2. AIDS
3. Candida
4. Herpes

(4) Acyclovir is anti-viral effective in shortening the duration of infection in Herpes. It is used in HIV and AIDS to treat opportunistic, viral infections but is not a primary AIDS drug. Candida is a fungus and is not responsive to an anti-fungal medication.

**155.** Amphotericin is the drug of choice for which of the following infections?

1. severe skin infection
2. endocarditis
3. life-threatening systemic fungal infection
4. severe pelvic inflammatory infections

(3) A serious antibiotic, amphotericin is an anti-fungal with a narrow therapeutic index and many side effects. It is given in the critical care setting after risk:benefit ratio concludes it is the best course of action.

**156.** A patient is taking Penicillin VK (Pen-Vee-K) for impetigo. Shortly after the first dose, he becomes flushed, weak, starts to itch, and is having trouble breathing. What is the most likely cause of the symptoms?

1. The wrong drug has been taken.
2. The patient may have pre-existing asthma.
3. The patient is probably on another drug (like Allegra or Tagamet) that is interacting with the penicillin.
4. The patient is having anaphylaxis.

(4) It is important that the nurse recognize early signs of allergic response but even more essential that she/he know the signs of life-threatening reactions. Asthmatic attacks are not typically associated with flushing and itching. Ingesting the wrong drug could precipitate an allergic reaction, but since penicillin accounts for the largest number of allergic responses of all medications, the nurse's first suspicion is that the client is allergic to the penicillin. A drug to drug interaction may precipitate an adverse response including respiratory and cardiac events, but one would not expect sudden flushing, itching, trouble breathing and collapse due to a combination of Allegra (fexofenadine) with penicillin. Tagamet (cimetidine) has been shown to interact withazole antibiotics but not penicillin. Anaphylaxis is airway and cardiovascular compromise precipitated by an allergic response.

**157.** A patient is diagnosed with peptic ulcer and prescribed Metronidazole (Flagyl) along with other medications. What rationale will the nurse teach the patient for the multi-drug regimen?

1. The drug will coat the stomach and let it heal.
2. The drug will block hydrochloric acid secretion from the mucosa.
3. The drug will treat the bacteria known as *Helicobacter pylori*.
4. The drug will inhibit the action of the proton pump in the stomach.

(3) The regimen for the treatment and eradication of *Helicobacter pylori* is a multi-drug antibiotic therapy.

**158.** The nurse is splashed in the face by blood when a chest drainage collection device breaks. What is the first action he should take?

1. Report to the infection control/employee health department.
2. Go immediately to the emergency services department.
3. Flush the area copiously with water.
4. Document an incident report.

(3) The first and most important action is to immediately wash the area copiously with soap and water (avoid eye exposure). Reporting to the emergency services would not be necessary unless the eyes were inoculated because first aid washing should occur at the site of the occurrence. Documentation of the occurrence should occur to protect the client in case of future problems. Copious flushing of the affected area is the first response to prevent transmission of infection. Reporting the incident and receiving further treatment are important follow-up.

**159.** The nurse is transporting a client on droplet isolation to the radiology department. Which of the following individuals must wear a mask?

1. nurse only
2. client only
3. nurse and client during transport
4. client and radiology staff who will receive the client

(2) The client only should wear a mask. This form of isolation is used for clients known or suspected as having a serious illness transmitted by large respiratory particles (droplets). Such illnesses such as strep pharyngitis, pneumonia, pneumonic plague, pertussis, and mumps are transmitted via droplets.

**160.** The nurse receives a client that is under contact precautions. What personal protective equipment will be needed for the client's morning care?

1. gloves
2. gloves, gown, mask
3. gloves, gown
4. gloves, gown, goggles

(3) Clients placed on contact precautions or isolation are known or suspected of an infectious illness that is transmitted by direct contact with the client or an item that the client has touched or used. Many wound infections, viral illnesses, parasitic infection (lice), infections of the GI tract such as *Clostridium difficile*, *Shigella*, and Hepatitis A, and respiratory syncytial virus. Unless a wound is being irrigated or items handled that could be splashed in the face, goggles are not necessary. Gloves and gown should be sufficient for the protection of the nurse providing morning care.

**161.** The nurse's hands are accidentally soiled with urine while assessing a client. What is the initial response?

1. Document the occurrence in the medical record.
2. Wash the hands with warm, soapy water.
3. Report to the infection control nurse immediately.
4. Document an incident form for risk management.

(2) Copious flushing of the affected area is the first response to prevent transmission of infection. Reporting the incident and receiving further treatment are important follow-up.

**162.** A needle/syringe once used should be disposed of by what method?

1. in the client's garbage
2. in a red, hazardous material bag
3. in a rigid sharps container
4. in any convenient and safe waste container

(3) Preventing needlestick injury and the transmission of bloodborne disease are the aims of proper syringe disposal. Hard, rigid containers are mandated by OSHA to be mounted on the walls in clinical areas. Biohazard emblems should designate their purpose. Other methods such as needle-less systems of syringes and the practice of not recapping needles should be employed.

**163.** Which of the following situations require the nurse to don gloves?

1. taking vital signs on a post operative client
2. giving a bed bath to a client who has had a myocardial infarction
3. small cuticle irritation on nurse's hand
4. combing the hair of a patient with fulminating AIDS infection

(3) An open lesion of the nurse's hand exposes patients to increased risk as well as allowing an open portal of entry for microbes into the nurse's body.

**164.** Which of the following statements defines Standard Precautions?

1. precautions taken in all situation involving blood and body fluids
2. control measures taken when a client is known to be infectious
3. control measures taken any time there is a suspicion of an infectious client
4. precautions taken when directly contacting clients

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

**165.** Which of the following situations require the nurse to don gloves?

1. taking a tympanic temperature on a post operative client
2. giving a sub cutaneous injection to a client on Heparin
3. assessing the heart rate of a patient with tuberculosis
4. assisting a patient to the bedside commode

(2) Standard precautions involving gloves are required when the possibility of coming in contact with body fluids exist whether blood is readily seen or not.

**166.** The nurse is splashed in the face by gastric secretions while aspirating a gastrostomy tube. What action should be taken first?

1. Wash her face with soap and water avoiding the eyes.
2. Report to the infection control/employee health department immediately.
3. Obtain a venapuncture from the nurse and the client for Hepatitis and HIV status.
4. Document an incident report.

(3) Flushing the area that is contaminated, immediately is the first response to being exposed to a biohazard such as gastric contents. It is not reasonable to obtain Hepatitis and HIV status of the client and nurse unless the nurse's eyes were inoculated or there was an open lesion on the face that could serve as a portal of entry for infection. Reporting and documenting and also necessary to ensure quality improvement and monitoring.

**167.** The nurse is teaching a client about communicable diseases and explains that a portal of entry could be:

1. vector.
2. a source like contaminated water.
3. food.
4. the respiratory system.

(4) The path by which a microorganism enters the body is the portal of entry. A vector is a carrier of disease, a source like bad water or food could be a reservoir of disease.

**168.** Which of the following microorganisms are considered normal body flora?

1. Staphylococcus on the skin
2. Streptococcus in the nares
3. Candida albicans in the vagina
4. Pseudomonas in the blood

(1) Only staphylococcus (in this question) is considered a normal resident of the body.



**169.** The spread of active or primary tuberculosis is primarily by what means?

1. blood
2. droplet
3. airborne
4. contact

(3) Although the tubercle bacillus can be spread from bovine to human via infected cow's milk, it is primarily spread by "sharing air" of the infected person, human to human contact.

**170.** The nurse teaching the client about Hepatitis and its transmission will explain that one type of Hepatitis does not produce a carrier state after its acute phase? Which type will she review?

1. Hepatitis A
2. Hepatitis B
3. Hepatitis C
4. Hepatitis D

(1) Hepatitis A does not produce a carrier state. It is transmitted via contaminated water/food via the oral-fecal route and is not bloodborne.

**171.** A pediatric client is diagnosed with acute glomerulonephritis. The nurse recalls that the disease is associated with which of the following?

1. a recent case of impetigo
2. a coexisting sore throat
3. a chronic cough
4. Dysuria

(1) A recent strep infection, within the past few weeks is associated with acute glomerulonephritis. Acute pharyngitis symptoms are not typical, and there is no cough or dysuria associated with the presentation. The hallmark signs of the disease are proteinuria, hematuria, edema, itching, and decreased urine output.

**172.** A neighbor telephones the nurse to tell her that her child has erythema infectiosum and asks for information. The nurse knows that another name for the disorder is:

1. Kawasaki disease.
2. Rheumatic disease.
3. Lupus erythematosus.
4. Fifth disease.

(4) The child has Fifth disease, a parvovirus, flu-like illness that is self limiting, but contagious for 2–3 weeks.

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

1. There is a slapped cheek appearance at the onset.
2. The disorder is common in adults.
3. There is fever.
4. The client is contagious until after the rash appears.

(2) Fifth disease, erythema infectiosum, is uncommon in adults. It is a viral infection that produces fever, rash, aches and the characteristic "slapped cheek" appearance. It can occur in adults but is more commonly seen in childhood.

**174.** Which isolation procedure will be followed for secretions and blood?

1. respiratory
2. standard precautions
3. contact isolation
4. droplet

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

**175.** Ethical and moral issues concerning restraints are all except:

1. emotional impact on patients/family.
2. informed consent.
3. quality of life.
4. standards of restraints and ethics.

(4) The use of restraints also raises many serious ethical and moral questions. Questions related to informed consent, quality of life, and autonomy are examples. Nurses contemplating using restraints must consider not only the possible physical and legal ramifications, but also the emotional impact on patients and families and the effect on a patient's self-concept. Being restrained is, in fact, personally demeaning to patients and deeply disturbing to them and their families. If nurses use restraints, they must consider this a short-term solution until more effective action can be planned.

**176.** Moving a restraint to a side rail or an immovable part of the bed can:

1. do nothing to the patient.
2. injure patients if the rail or bed is moved and they have restraints in place.
3. help the patient stay in the bed without falling out.
4. help the patient with better posture.

(2) Do not attach restraint to side rail or to an immovable part of the bed or chair. This could injure patient if rail or bed is moved before releasing restraints. Tying a restraint to some types of springs may result in the tie becoming entangled at the point where two spring wires cross. In this case, tie the knot across the junction of the two spring wires, rather than between them as illustrated, or tie the restraint to a solid part of the bed frame out of the patient's reach.

**177.** Padding on the restraint helps:

1. to distribute pressure so bony prominences do not receive pressure when the patient pulls against the restraints.
2. to tie with padding on buttock and under hips, so patient will feel more secure.
3. to keep infection and wounds down.
4. to keep the restraints in place.

(1) Padding distributes pressure so that bony prominences do not receive the brunt of pressure when patient pulls against restraint. Pressure, especially over bony prominences, causes tissue damage due to ischemia.

**178.** What does communication/education with the patient and family, concerning restraints do?

1. confuse both groups more
2. helps coping and the stress level
3. provides more cooperation with patient and family
4. helps to put the responsibility on the patient/family and not nurse.

(3) Cooperation is more likely if patient and family understand the purpose of and expected gains from restraints. Well-meaning family may release restraints if purpose is not clear.

**179.** The nurse working with older adults keeps in mind that falls are most likely to happen to older adults that are:

1. in their 80s.
2. living at home.
3. hospitalized.
4. living on only social security income.

(3) Older people are particularly prone to falling and incurring serious injury; particularly in new situation and environment as the hospital.

**180.** The nurse assesses a client for physiological risk factors for falls. The nurse would conclude that the client is at no further risk if which of the following were discovered?

1. history of dizziness
2. need for wheelchair due to reduced mobility
3. weakness and fatigue noted when climbing stairs
4. intact recent and remote memory

(4) Risk for falls can occur in the older patient. The nurse should assess each client for possibility of falls and take appropriate actions.

**181.** Clients who are at risk from alcohol or drug consumption or who have a cerebrovascular accident, cardiac arrest, are at most risk for:

1. infection.
2. immobility.
3. falls.
4. fire hazards.

(3) Clients that are at most risk for falls are usually the older client with severe disease conditions; physical or psychological factors; or other social problems.

**182.** Potential hazards for falls in the home are all except:

1. missing or broken steps.
2. presence of throw rugs.
3. inadequate lighting.
4. lifestyle that promotes health.

(4) Potential hazards in the home are inadequate lighting, missing or broken steps or handrails, or the presence of throw rugs.

**183.** Release of restraints in most facilities should be done, how often?

1. every 2–4 hours
2. every 1–3 hours
3. every 30 minutes
4. after 4+ hours

(1) Assess the restraint every 30 minutes. Some facilities have specific forms to be used to record ongoing assessment. Release all restraints at least every 2–4 hours and provide range-of-motion (ROM) exercises and skin care. Reassess the continued need for the restraint at least every 8 hours. Include an assessment of the underlying cause of the behavior necessitating use of the restraints.

**184.** Which of the following statements describes the purpose of patient restraint?

1. a nursing measure to maintain client control
2. an emergency intervention taken as a last resort to protect a patient from imminent danger
3. a therapeutic measure designed to positively reinforce patient behavior
4. an emergency measure that can only be taken by a nurse under the direct supervision of a physician

(2) The use of restraints as an emergency measure is taken primarily as a last resort to protect a patient from harm. Typically, the nurse acts under a physician's order, but in an emergency, he may of necessity restrain a patient for one hour prior to the patient being seen by a physician or an advanced practice mental health provider.

**185.** The nurse will perform which intervention when the client is restrained?

1. Remove the restraints and provide skin care hourly.
2. Document the condition of skin every 3 hours.
3. Assess the restraint every 30 minutes.
4. Tie the restraint to the side rails.

(3) Although agency protocols may be more rigid and will vary, the minimum standard is to visually assess the restraint every 30 minutes. Documentation is typically done per a checklist or flow-sheet. The ends of the restraint are tied to a part of the bed that allows for position changes without injury to the client.

**186.** Which of the following parameters for the use of restraints is incorrect?

1. discipline
2. maintain safe environment for other patients
3. prevent harm to the patient or others
4. emergency situation with no other safe alternative

(1) Restraints should never be used to punish or discipline a patient. The purpose of restraint is only for the protection of the patient or others at risk for harm. The decision to restrain is associated with an urgent or emergent setting.

**187.** A nurse should attempt which of the following measures first prior to restraining a client?

1. Determine whether there could be a more convenient way of managing the client.
2. Obtain consent from the client or the client's guardian.
3. Assess the client's skin and vital signs.
4. Document the circumstances surrounding the need for restraints in the medical record and ensure a physician's order.

(2) Initial nursing action should involve obtaining the client's consent. Restraints are not to be used as a convenience for nursing care. Certainly, a physician's order is needful, but if a patient is "at risk," restraint can be done, and then an MD order obtained. Documentation is not the priority in the emergency restraint setting, but should be thoroughly and thoughtfully done as soon as possible.

**188.** Which of the following statements describes the purpose of patient restraint?

1. A nursing measure to maintain client control.
2. An emergency intervention taken as a last resort to protect a patient from imminent danger.
3. A therapeutic measure designed to positively reinforce patient behavior.
4. An emergency measure that can only be taken by a nurse under the direct supervision of a physician.

(2) The use of restraints is an emergency measure often taken as a last resort to protect a patient from harm. Typically, the nurse acts under a physician's order, but in an emergency he may of necessity restrain a patient for one hour prior to the patient being seen by a physician or an advanced practice mental health provider.

**189.** A specific requirement regarding the restraint of children is:

1. a child can be restrained under certain circumstances where standards have been developed.
2. as with all procedures, children under 12 do not require informed consent prior to restraint.
3. children should receive mild sedation prior to the application of mechanical restraints.
4. a child cannot under any circumstances be chemically restrained.

(1) Children may be mechanically restrained under similar rationale as the adult, for their own protection or to perform a medical intervention. It is always appropriate to explain procedures and to secure consent if possible. Physical restraint should never be used as a substitute for good nursing care, for punishment, or convenience to the staff. The safety of the child is the paramount principle guiding the use of restraints.

**190.** Parameters for the use of restraints involve all of the following except:

1. discipline of an unruly client.
2. maintaining a safe environment for other patients.
3. preventing harm to the client or others.
4. in an emergency situation with no other safer alternative.

(1) Restraints should never be used to punish or discipline a patient. The purpose of restraint is only for the protection of the patient or others who may be at risk for harm.

**191.** A nurse should attempt which of the following measures prior to restraining a disruptive patient?

1. patient teaching including possible etiology of the patient's behavior
2. removal of the client from stimuli
3. firm reminder of penalties regarding unacceptable behavior
4. confrontation regarding the client's behavior

(2) Removal from stimuli inciting or exacerbating the undesirable behavior is the most important measure the nurse can take when a patient is "escalated" and at risk for harm to self or others. Patient teaching is not effective in emotionally charged settings, and firmness and confrontation are used only at great discretion as these actions may incite further negative behavior and may even provoke violence.

**192.** The nurse recognizes which correct principle guiding the use of side rails?

1. Side rails are used most frequently as a precaution against falls in the elderly.
2. Side rails are a form of restraint.
3. Side rails should be up anytime a patient is at risk for falling.
4. No special consent is necessary for the use of side rails.

(2) Side rails are restraining devices and may contribute to falls in many circumstances. Typically, an increased risk for falling has been identified and a physician's order obtained prior to their use. The use of side rails should be based on the agency's policy and the needs of the patient. For example, a patient who has received a sedative hypnotic or mood altering medication would likely need side rails to decrease the risk of falling.

**193.** The legal offense committed by the unpermitted touching of another is:

1. assault.
2. battery.
3. coercion.
4. intimidation.

(2) Criminal and or civil battery is generally defined as an intentional and/or unpermitted act of offensively touching another. Healthcare providers including nurses may be held civilly and criminally liable for inappropriate, illegal restraint. To the extent reasonably possible, the patient should understand and consent to restraint as a mechanism for

protecting himself or others from harm. Assault is legally defined as placing another in apprehension of an imminent, offensive touching. Coercion and intimidation may be characteristics of assault and/or battery but are not of themselves criminal or civil acts of disobedience as defined by law.

**194.** The nurse will select a “poncho” or torso-type vest restraint for what client?

1. a 3 year old undergoing suturing of a scalp laceration
2. a teenager who is admitted after drug overdose with altered mental state and is intubated
3. a frail, elderly client diagnosed with “Senile Dementia of Alzheimer’s” who wanders
4. a middle aged adult with psychosis who has fallen previously

(4) A jacket-type restraint is indicated for the adult client, particularly one who has fallen previously and may be at high risk for a subsequent fall. The jacket/torso restraint would be an inappropriate type of restraint for a three year old and could pose a choking or restricting/vice type hazard. Restraint for a surgical intervention, repair of a scalp laceration would necessitate the child’s hands being restrained, which a jacket would not provide. A teen who is admitted with drug overdose and altered mental state and who is intubated may remove her airway; therefore, the hands should be restrained. A frail, elderly wanderer would be more comfortable and less “confined” yet safer in a geri-chair or rolling walker device.

**195.** The nurse will select a “belt” or safety-strap restraint for what type of client?

1. clients being moved
2. clients in seclusion
3. clients in surgery and special procedure areas
4. pediatric clients

(1) Clients being moved may be placed in the belt-type restraint to assist the caregiver with safe moving from stretcher to stretcher, bed to chair, and chair to standing position. The belt restraint would be an inappropriate choice for children as it may pose a strangulation risk if a small child “wriggled” out of the restraint into a restrictive, gradually tightening position that could lead to limb injury or asphyxiation.

**196.** When there is ample time to prepare to restrain a client, staff should do all of the following. If it is vital to restrain the client quickly, which component can be done after the restraint procedure?

1. Obtain a physician’s order for restraints.
2. Remove personal articles that the client can use to harm staff.
3. Continuously assess the client’s level of dangerousness.
4. Have adequate staff available to prevent client and staff injury.

(1) Unless options 2, 3, and 4 are carried out, the staff or the client may be at greater risk of injury. Rarely would a physician refuse to write this order after the fact. Such an order also can be included as part of an institutions protocol for care of the potentially violent client; notify any relatives.

**197.** A 65-year-old client is hospitalized with shortness of breath and seizure precautions. He is unable to ambulate without help but becomes disoriented at times and tries to get out of bed. What is the most appropriate safety measure for this client?

1. Restrain the bed.
2. Ask a family member to stay with the client.
3. Check the client every 15 minutes.
4. Use a bed exit safety monitoring device.

(4) An intervention that can allow the client to feel independent and can alert the nursing staff if the client needs help; it is the best answer for self-esteem and safety. Option 1 may increase the loss of independence; option 2 could be within safety precautions, but the reliability still is with the nursing staff; option 3 is unrealistic for the nursing staff to be able to check on the client every fifteen minutes.

**198.** Before selecting a restraint, the nurse needs to understand all except:

1. the purpose clearly.
2. the health problem or treatment is not impaired.
3. it is a safe procedure.
4. the family visitors can easily see the restraint.

(4) The restraints should be less obvious to the client and visitor; so that the environment becomes more comfortable for them.

**199.** Restraints are used as:

1. protective devices.
2. relaxation devices.
3. holistic devices.
4. injury devices.

(1) Restraints are protective devices used to limit physical activity of the client or a part of the client's body. The nurse should understand its purpose and the client's needs; its safety for the client's treatment or health problem.

**200.** Under standards and policies of an institution, who is designated to have the responsibility for using restraints?

1. Client must request restraints.
2. Family must request restraints.
3. Physician must request restraints.
4. The roommate of client can request restraints.

(3) The standards for the use of restraints must be a physician's order. The time period, safety, and monitoring must be specified. Use of restraint must be monitored under specific guidelines and standards. The nurse has the responsibility to collaborate with the physician and medical personnel in the safety and welfare of the client. Both the psychological and the physiological considerations must be of utmost concern of the nurse.

**201.** What are the alternatives that the nurse can use, before applying restraints? All except:

1. place unstable clients in an area that is constantly or closely supervised.
2. lower all medications, so the client is more stable.
3. wedge pillows or pads against the sides of wheelchair and bed to keep clients well positioned.
4. position beds at their lowest level to facilitate getting in and out of bed.

(2) Monitor all the client's medications and, if possible, attempt to lower or eliminate dosages of sedatives and psychotropics; establish ongoing assessment to monitor changes in physical and cognitive functional abilities and risk factors.

**202.** What organizations does the nurse need to know about before applying restraints?

1. County Health Department policies
2. U.S. Centers for Medicare and Medicaid Services
3. National Drug and Alcohol Centers
4. American Nurses' Association

(2) The U.S. Centers for Medicare and Medicaid Services published revised standards for use of restraints in the United States in 2000. These standards apply to all healthcare organizations and specify two standards for applying restraints: the Behavior Management Standard and the Acute Medical/Surgical Care Standard.

**203.** What time frame must the physician or nurse practitioner use with the Behavior Management Standard (restraints)?

1. A written restraint order for an adult, following evaluation, is valid for 4 hours.
2. Written restraint order is valid only for 2 hours.
3. The nurse can make the judgment based on the individual client.
4. Written restraint order—PRN

(1) Written restraint order for an adult, following evaluation, is valid for only 4 hours. A visual and audio monitoring of the client's status must be done. The PRN order for restraints is prohibited.

**204.** The role of the incident report in risk management is which of the following?

1. protects from liability
2. analyzed by a risk manager to determine how future problems can be avoided
3. for disciplining staff for errors
4. all of the above

(2) Incident reports are not protective from liability. They are a tool for documentation of the occurrence of an incident. Incident reports are not to be used for disciplining staff.

**205.** A risk management program within a hospital is responsible for all of the following except:

1. identifying risks.
2. controlling financial loss due to malpractice claims.
3. making sure that staff follow their job descriptions.
4. analyzing risks and trends to guide further interventions or programs.

(3) Risk management is an organization-wide program to identify risks, control incidents, and legal liability. It does not have any direct supervisory or management responsibility for staff.

**206.** How is the information documented on incident reports used?

1. analyzing risk categories
2. making sure procedures are in compliance with regulations
3. identifying the educational needs of the staff
4. all of the above

(4) Risk management plays a vital role as an arm of quality monitoring and improvement programs. It utilizes information obtained from incident reports, as well as audits, committee minutes, service complaints, and patient satisfaction questionnaires to perform all of the tasks identified.

**207.** The incident report itself includes all of the following information except:

1. staff person responsible for the incident.
2. who the incident involved.
3. a description of the incident.
4. a signature of who prepared the report.

(1) No nurse or staff is blamed on an incident report. Documentation includes who was involved in the incident in addition to a description of what happened or what the incident was. The report must always be signed by the person preparing the report.



**208.** As the charge nurse, you reviewed an incident report written on the last shift. It contained the following note:

“Mrs. C was found lying on the bathroom floor, complaining of pain and a bump on the head. No injuries noted. Dr. notified.”

The significant details missing from the documentation include:

1. How was she lying on the floor? Description of pain? What were the immediate interventions when she was found?
2. How did she get to the bathroom? Had she been incontinent?
3. Was her call bell in reach? Has she fallen before?
4. How steady was her gait? Has she recently been medicated?

(1) Further objective description should be documented as to the patient’s status at the time she was found. In addition to more descriptive assessment information, the nurse must also include what was administered in the way of care.

**209.** From the previous scenario, which of the following notes contain all the required elements in documenting an incident?

1. “Mrs. C was found lying on her left side on the bathroom floor, complaining of left arm pain and a bump on the head.”
2. “Mrs. C was found lying on her left side on the bathroom floor, complaining of left arm pain and a bump on the head. She was lifted back to bed by four staff members and given her call light.”
3. “Mrs. C was found lying on her left side on the bathroom floor, complaining of left arm pain and a bump on the head. She was awake, alert, and appropriate. She stated, ‘Boy, my foot just slipped out from under me.’”
4. “Mrs. C was found lying on her left side on the bathroom floor, complaining of left arm pain and a bump on the head. She was awake, alert, and appropriate. She stated, ‘Boy, my foot just slipped out from under me.’ Her vital signs were at her baseline: BP 138/72, pulse 78 and regular, respirations 16 per minute, and temp 97.4 orally. No bruising or edema noted. She was lifted back to bed by four staff members and given her call light.”

(4) This note provides necessary detail regarding a description of the incident, the patient’s assessment, and immediate interventions.

**210.** Typical areas of high risk for employees related to their job requirements within a healthcare facility include all of the following except:

1. food served in the cafeteria.
2. employee prevention of back strain.
3. stress injuries for example carpal tunnel.
4. employee stress in high acuity areas (for example, critical care).

(1) Risk management’s role with prevention of known risk factors is focused on employee wellness and prevention of injury. Common frequently occurring incidences are: back strain, carpal tunnel, and stress or burnout in high patient acuity areas. These problems are not only significant to the individual(s) involved but also impact the facility in terms of time off work, staffing adequacy, and possible disability issues.

**211.** High risk aspects of care that have been high volume over the last decade or so include all of the following except:

1. needlestick injuries.
2. falls.
3. restraints.
4. meals.

(4) Three of the most significant high risk care aspects are: needle stick injuries (due to the risks associated with disease transmission), falls (due to resultant injuries, functional decline, and financial liabilities), and use of restraints. Even though the laws now require a minimal restraint application, injuries sustained from use of restraints have been a significant problem.

**212.** As risk management has trended information obtained from incident reports, what time of day has been identified as the most problem prone in terms of incident occurrence in hospitals?

1. bedtime
2. between 5:00 and 6:00 in the morning
3. at nurse's change of shift
4. meal times

(3) Incidents have been trended to occur with the greatest frequency during the nursing change of shift. This is explained by nurse's attention, availability, and efforts being directed away from direct patient care at this time.

**213.** Studies have demonstrated that the compliance rate of documenting incidents in healthcare is:

1. 100 percent
2. 50 percent
3. 30 percent
4. 1–5 percent

(4) Although somewhat speculative, it is believed that a very small percentage (1–5 percent) of actual incidents that occur in healthcare are documented.

**214.** The public's sources for accessing information regarding incidents that occur in a healthcare facility are:

1. the facility itself.
2. the American Hospital Association.
3. the Web site for the Department of Health and the Agency for Health Care Administration.
4. information is not accessible.

(3) On Web sites maintained by the Department of Health and the Agency for Health Care Administration, the public has access to a doctor's history, including education, disciplinary actions, and malpractice payments. They can obtain a copy of the Patient's Bill of Rights. In addition they can review annual trends of "adverse incidents"—such as patient death, operating on the wrong patient or the wrong part of the patient, or foreign objects left in the patient.

Hospitals and other facilities must follow some legal guidelines for reporting adverse incidents to AHCA at three times: within 24 hours after the incident took place, 15 days after the incident, and in their annual report. The public has access to general accumulated data released by AHCA on an annual basis.

# Health Promotion and Maintenance

This chapter contains questions and answers from the following topic areas:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Data Collection Techniques
- Developmental Stages and Transitions
- Disease Prevention
- Expected Body Image Changes
- Family Planning
- Growth and Development
- Health and Wellness
- Health Promotion
- Health Screening
- High Risk Behaviors
- Human Sexuality
- Immunizations
- Lifestyle Choices
- Principles of Teaching/Learning
- Self-Care
- Techniques of Physical Assessment

**1.** When assessing an elder client's physical activities of daily living, which of the following skills would the nurse expect the client to lose first?

1. transferring
2. dressing
3. feeding
4. bathing

**(4)** There are six basic skills associated with activities of daily living: bathing, dressing, toileting, transferring, continence, and feeding. The skills are assessed in the order just listed because this is also the order in which the skills are usually lost. If the elder is able to have rehabilitation care, the skills are regained in reverse order.

**2.** All of the following activities are included when the nurse assesses the instrumental activities of daily living in an elder client except:

1. transfer from the wheelchair to the bed.
2. manage their medications.
3. do housework and laundry.
4. manage their finances.

**(1)** There are two basic components to a functional assessment. The physical activities of daily living that are necessary for someone to survive without help and the instrumental activities of daily living that include activities needed to live independently. Transferring from the wheelchair to the bed is a physical activity of daily living. Options 2, 3, and 4 are all instrumental activities of daily living.

**3.** Which of the following is the most common mental health issue among older adults?

1. dementia
2. depression
3. substance abuse
4. suicide

(2) Depression is the most common mental health illness of older adults. It is often unrecognized and undertreated. This leads to decreased functioning and independence. Dementia, substance abuse, and suicide are also common mental health illness in older adults.

**4.** When an elder client with Parkinson's Disease experiences an exacerbation of melanoma, which of the following medications would be the most important for the nurse to question?

1. Seligiline hydrochloride (Eldepryl)
2. Tolcapone (Tasmar)
3. Levo-dopa (L-dopa)
4. Amantadine (Symmetrel)

(3) There have been some reports of new growth or exacerbation of melanoma in client's taking Levo-dopa. Although the link between the drug and melanoma have not been proven, there is enough concern in the literature to warrant caution and careful monitoring. There are no associations of melanoma with Eldepryl, Tasmar, or Symmetrel, all of which are also used to treat Parkinson's Disease.

**5.** When a hospitalized elder adult has a nursing diagnosis of altered mental status, which nursing measures should be included in the plan of care?

1. Place them in a room with another elder client.
2. Leave the TV on all the time.
3. Leave the light on all the time.
4. Reorient them frequently.

(4) Confused or disoriented elder clients should be gently reoriented frequently. It is unrealistic to expect them to always be oriented to the date and time after a few days in the hospital, but they should be oriented to more global issues such as the month, year, city, who's president, and so on. These clients should be placed in a private room with a window if possible. Putting them in with other elder clients, who may also be disoriented, may magnify their confusion. The TV should not be left on all the time. Many older adults do not like it or do not like the channels someone else would choose for them. In their confusion, they may also begin to believe that everything they see on TV is really happening and become frightened. Leaving the light on all the time deprives them of the normal circadian rhythms of light and dark. A nightlight that would allow them to see the room should they try to get up may be useful to prevent falls.

**6.** If an elder client has Acetaminophen with codeine ordered for pain, which of the following should be considered by the nurse when evaluating the therapeutic effect?

1. Concurrent administration of Tagamet (cimetidine) will potentiate the effects.
2. Doses over 65 mg will increase relief but may have increased side effects.
3. Quinidine administration will prevent the conversion of codeine to morphine.
4. There are increased gastrointestinal side effects with doses greater than 1 mg/kg/day.

(3) Quinidine interferes with the conversion of codeine to morphine in the body so that if the patient were taking both drugs, the acetaminophen with codeine would not relieve the client's pain. The same is true of Tagamet. Potentiate means that Tagamet would increase the desired effects of the drug. If it actually prevents how the drug works, then it would decrease or eliminate the desired effects of acetaminophen with codeine. Doses greater than 65 mg will not increase pain relief but will increase the adverse effects. The gastrointestinal side effects are increased with doses greater than 1.5 mg/kg/day. Long-term use of acetaminophen with codeine is not considered safe for older adults.

**7.** When observing elders with swallowing disorders, which of the following signs and symptoms would indicate to the nurse that the client may have aspirated?

1. complaint of food caught in the back of the throat
2. fever of unknown origin
3. request for something to eat or drink
4. lack of functional cough

(2) Difficulty swallowing (dysphagia) occurs in about 12 percent of hospitalized clients and is two times that amount in stroke patients. Studies have shown that a high percentage of elder clients in rehab hospitals have already aspirated prior to admission. The nurse has to have a high index of suspicion for infection in older adults, particularly when fever is involved, because of the poor immune response. If the fever can't be explained by another disease process, aspiration pneumonia should be considered. Older adults may complain of food caught in the back of their throat, but studies have shown that there is not a positive correlation between that complaint and the presence of aspiration. If the client has aspirated, there is usually a lack of interest in or refusal to eat and drink. The cough reflex is decreased in older adults, and clients with functional coughs can still aspirate, so functional cough is not a good indicator of aspiration in the older adult.

**8.** When an older client is at risk for choking or aspiration, which of the following nursing interventions should be included in the plan of care?

1. Use a syringe to feed the client.
2. Remove dentures prior to feeding.
3. Provide a straw for liquids.
4. Avoid milk products.

(4) When an older client is at risk for choking or aspiration, milk products should be avoided, particularly if the client already has thick secretions. Milk will thicken the secretions, decreasing the client's ability to expectorate and lead to infection. Syringes should be avoided when feeding clients at risk for choking or aspiration. The injection force can actually precipitate choking or aspiration. Dentures should be in place and secure prior to feeding. Unless specifically ordered by the speech pathologist, straws should be avoided in these clients because of the coordination required for their use.

**9.** When assessing clients who are 65 years of age, which of the following clinical manifestations would a nurse expect to identify the most?

1. difficulty performing one or more physical activities of daily living
2. difficulty performing one or more instrumental activities of daily living
3. pain
4. osteoarthritis

(3) The percentage range of older adults reporting pain is 70–80 percent. Among older adults pain is reported to be the one clinical manifestation that interferes the most with activities of daily living and social interaction. Thirteen percent have difficulty performing one or more physical activities of daily living. Seventeen and a half percent have difficulty performing one or more instrumental activities of daily living. Forty-nine percent of 65 year olds will have arthritis/musculoskeletal disease. By the time adults reach 75 years of age, 80 percent of them will have osteoarthritis.

**10.** All of the following characteristics are associated with adverse drug effects in the older adult except:

1. increased body weight.
2. female gender.
3. hepatic insufficiency.
4. polypharmacy.

(1) A decreased body weight is associated with adverse drug effects in the older adult. Female gender, hepatic insufficiency, and polypharmacy are also associated with adverse drug effects in older adults. Additional characteristics include renal insufficiency and previous drug reactions.

**11.** Which of the following medications has higher serum levels as a result of reduced lean body mass in the older adult?

1. Lithium
2. Digoxin
3. Barbiturates
4. Phenytoin

(2) Because Digoxin is not very fat soluble it does not get distributed to adipose tissue. So, the loss of lean body mass in older adults means that serum Digoxin levels are elevated. Lithium is water soluble. Older adults have a reduction in total body water, so they would have higher lithium levels. Barbiturates and Phenytoin are both fat-soluble medications. Since there is a higher percentage of body fat in older clients, drugs stored in the fat have a prolonged half-life.

**12.** When an older adult has delirium, the nurse should expect the client to demonstrate which of these behaviors?

1. normal sleep
2. gradual onset
3. delusional thought
4. fluctuating levels of consciousness

(4) Clinical manifestations differ between delirium and dementia. Fluctuating levels of consciousness are consistent with delirium, whereas normal level of consciousness is associated with dementia. Normal sleep is associated with dementia. Disturbed sleep is associated with delirium. Delirium has a rapid onset, and dementia has a gradual onset. Delusional thought is associated with dementia. The thought processes of delirium include incoherency and confusion.

**13.** All of these strategies are used by the nurse when planning care for an older adult who is at risk for falling except:

1. anticipate and meet elimination needs.
2. assign a room close to the nurse's station.
3. use restraints when family members cannot stay.
4. answer the signal light or buzzer as soon as possible.

(3) The use of restraints should be avoided or used only as a last resort. If they are used, all the protocols and policies of the institution must be strictly adhered to. There are many restraint-free facilities that adjust the environment to reduce the risk of injury when falls occur. Most falls of older adults occur between 8:00 AM and 5:00 PM when the older adult is trying to get to the bathroom. Anticipating and meeting their elimination needs can prevent falls by providing assistance before it is needed. Placing older clients at risk for falling closer to the nurses station allows the nurses to more closely monitor the clients and hear any calls for help. Answering the signal light or buzzer as soon as possible will teach the older adult that help does come when asked for, and hopefully, they will learn to wait for help before getting up alone.

**14.** All of the following interventions may be directed toward preventing an older adult from wandering away from the long-term care facility except:

1. install waist-high fences at the door.
2. reorient them to the current activity.
3. provide a rocking chair.
4. place a chair by the window.

(2) One of the reasons the client may begin wandering away is that they are bored with the current activity or aren't interested in it. Redirect their attention to another activity. Waist-high fences at the door might prevent the client from going through the door but allows the oriented staff and visitor's entrance and exit. Rocking chairs might prevent wandering by providing a comforting rhythm and repetitive motion. Rocking wheelchairs are available. Placing a chair by the window so the client can see outside might satisfy their desire to go outside and prevent wandering.

**15.** All of the following nursing interventions should be included in the plan of care when an older adult has a nursing diagnosis of risk for impaired mobility except:

1. avoid chairs that are soft and low.
2. allow for bathroom breaks every 30–60 minutes.
3. use gentle touch to convey trust.
4. sit at the same level as the older adult.

(1) Option 1 is the only intervention listed that directly relates to the nursing diagnosis of risk for or impaired mobility. Soft and low chairs should be avoided because they are difficult for the older adult to get up from. Allowing for bathroom breaks is a nursing intervention for the nursing diagnosis of risk for or alteration in elimination patterns. Using gentle touch is therapeutic for the nursing diagnosis of risk for or alteration in sensory-perceptual loss. Sitting at the same level as the patient is another nursing intervention for risk for or alteration in sensory-perceptual loss.

**16.** Which of the following clinical findings are normal age-related changes in the older adult woman's breast tissue?

1. hypertrophy of mammary tissue
2. decrease in adipose tissue
3. slight decrease in breast size
4. increased protrusion of the nipple

(3) The breast slightly decreases in size when women are older. In older women, mammary tissue atrophies; there is an increase in adipose tissue and a flattening of the nipple.

**17.** The nurse observes that an elder client walks with decreased step height and length, increased speed, and shuffles. The client's posture is stooped, and there is hesitation in both initiation and termination of ambulation. When standing the knees are flexed and the body position is rigid. The nurse documents this as which of the following gait types?

1. antalgic
2. apraxic
3. Trendelenburg
4. festinating

(4) The gait described is called festinating and is the typical gait for Parkinson's Disease. Antalgic gait refers to limited weight bearing when using an affected limb to avoid discomfort. Antalgic gait is characteristic of degenerative joint disease of the hip or knee. Apraxic gait is evidenced by difficult walking despite intact motor and sensory systems. The client is unable to start ambulation. After walking is begun there is a shuffling and slow gait. Trendelenburg gait occurs when the pelvis of the unaffected side drops when the client weight bears while walking. If both hips are affected, the nurse may observe a waddling gait. Trendelenburg gait is typical of clients with developmental dysplasia of the hip or muscular dystrophy.

**18.** When caring for a dying elder, the nurse should recognize which of the following behaviors as regression?

1. acceptance
2. denial and projection
3. abstract thinking
4. full use of speech

(2) Dying elders may resist emotional involvement in their care and planning. Their behavior may regress. A clear behavior sign of regression is denial and projection. Acceptance is not a sign of regression. Rather than being able to think abstractly, dying elders in regression are preoccupied with minutiae and have decreased ability to even engage in simple abstractions. Speech patterns in a dying elder that are consistent with regression include misuse of words, misinterpretations, and utilization of fragments of speech.

**19.** Which of the following statements, when made by an elder client, should indicate to the nurse successful aging?

1. "I have so many regrets about my life."
2. "I don't know how I'm going to make it financially."
3. "I'm going to go fishing and have a good time."
4. "I haven't talked to my kids in over two months."

(3) One of the characteristics of successful aging is having a high degree of satisfaction with life. That is evidenced in part by elders being able to relax and enjoy their interests. Expressing regret about how they have lived their life is an indication of dissatisfaction with their life and does not indicate successful aging. Another characteristic of successful aging is having established financial security. If the elder, as stated in option 2, is financially insecure, then they have not attained successful aging. Maintenance of a meaningful social system is another characteristic of successful aging. This includes maintaining their involvement with family and friends. Two months is a long time for an elder to go without contact with their family and might indicate unsuccessful aging.

**20.** The care plan for an elder client who has papillary and lens changes should include which of these measures?

1. Use direct light for visual work.
2. Work on white surfaces.
3. Wear tinted glasses.
4. Drive when the sun is shining.

(3) Because of the papillary and lens changes associated with aging, the elder will have a decreased tolerance to glare or light changes. Wearing tinted glasses or a brimmed hat can reduce the glare or bright lights that interfere with the elder's ability to see. Indirect lighting should be used for visual work. It allows better perception of stimuli. White or glossy surfaces should be avoided because of decreased perception of stimuli. Encourage the elder to use color contrast for work areas. Caution should be used when the elder is driving. Driving in bright sunlight or at night can be problematic and will require additional safety considerations. If they must drive in the sun, the use of sun glasses is important.

**21.** The nurse would plan to teach an elderly client which of these strategies to care for their skin?

1. Bathe with hot water.
2. Avoid emollients/lotions.
3. Avoid use of cosmetics.
4. Drink adequate water.

(4) As aging occurs, the number of sweat glands is reduced, which interferes with the ability to sweat and regulate body temperature. The elder client also has decreased ability to retain fluids, causing the skin to become drier and less flexible. The elder should drink adequate water to ensure thermoregulation and hydration of the skin. This will help prevent other complications resulting from aging skin. Elder clients should avoid hot water when bathing and the use of excessive soap. Because there is decreased pain sensation, the elder could easily become burned with hot water. Excessive soap will dry the skin even more, and this is already a problem of aging skin. Cosmetics can assist the elder with the body image changes associated with aging and with restoring some of the lost color. Their use should not be discouraged.

**22.** All of these generalized physiologic changes are associated with aging except:

1. stable reserve functional capacity.
2. decreased rate of cell mitosis.
3. deterioration of specialized nondividing cells.
4. increased rigidity and loss of elasticity in connective tissue.

(1) The reserve capacity lessens with age. This phenomenon refers to the ability of the body to increase its usual effort when stressed. Options 2, 3, and 4 are all physiologic changes associated with aging.



**23.** The nurse should recognize that all of the following physical changes of the head and face are associated with the aging client except:

1. pronounced wrinkles on the face.
2. decreased size of the nose and ears.
3. increased growth of facial hair.
4. neck wrinkles.

(2) The nose and ears of the aging client actually become longer and broader. The chin line is also altered. Wrinkles on the face become more pronounced and tend to take on the general mood of the client over the years. For example laugh or frown wrinkles about the eyebrows, lips, cheeks, and outer edges of the eye orbit. The change in the androgen-estrogen ration causes an increase in growth of facial hair in most elder adults. The aging process shortens the platysma muscle, which contributes to neck wrinkles.

**24.** An elder client complains to the nurse that he is having more difficulty in seeing colors. To assist the client in seeing color better the nurse should suggest increased use of which of the following colors?

1. blue
2. green
3. yellow
4. red

(4) Brighter colors help compensate for the decrease of color discrimination associated with aging such as yellowing and opacity of the lens. The first color to be affected is blue, followed by green and then yellow. Red has longer wavelengths and is the last color to be affected by the aging process.

**25.** The medical record of an elder client reveals presbycusis. Which of these history findings should the nurse expect to identify?

1. a history of a bacterial brain infection
2. prolonged exposure to loud noise
3. inability to distinguish directions of sound
4. history of a head injury

(3) Presbycusis is the most common cause of hearing loss in the elderly. It is characterized by progressive hearing loss and sound discrimination. The inability to distinguish from what direction a sound came is expected with this type of hearing loss. Other manifestations include difficulty hearing consonant sounds such as s, sh, ch, th, dg, z, and f; difficulty hearing high frequencies; and difficulty hearing persons who speak rapidly. Sensorineural deafness is characterized by the findings listed in options 1, 2, and 4.

**26.** The teaching plan for an elder client with decreased taste and smell sensation includes all of the following except:

1. add more spices and herbs to food.
2. be sure that smoke detectors are in working order.
3. add salt and sugar to food as needed.
4. maintain adequate diet intake.

(3) As people age they experience an increased desire for spicy foods, salt, and sugar. This can be attributed to the decreased number of taste buds, slower processing in the CNS of taste perception, and diminished salivation. Adding more spices and herbs to their food can help compensate for these losses and cause them to enjoy their food more. Adding salt and sugar to their food should be avoided as many elders have medical problems such as diabetes and hypertension. A contributing factor to decreased taste is a simultaneous decrease in smell. A loss of smell puts the elders at risk of not knowing when gas is leaking, when there is spoiled food, or if something is burning. Having working smoke detectors is a compensatory safety intervention for the loss of smell. When elders have decreased taste and smell, they are prone to not eat adequate diets. The nurse should encourage them to maintain an adequate diet even if they can't taste or smell the food they are eating.

**27.** An elder male experiences urinary frequency, difficulty starting the urinary stream, dribbling, and retention of urine. The nurse should recognize these clinical manifestations as indicative of:

1. normal physiologic changes of aging.
2. prostatic hypertrophy.
3. urinary tract infection.
4. poor toileting habits.

(2) Prostatic hypertrophy results when the changes of the smooth muscle fibers of the prostate occur with age. The symptoms experienced by the man include those listed in the question. Although these changes are associated with aging, they are very specific to prostatic hypertrophy. Urinary tract infections can result from prostatic hypertrophy because of the stasis of urine, but not every male with prostatic hypertrophy will have a UTI. Poor toileting habits can lead to UTIs and incontinence, not to prostatic hypertrophy.

**28.** When an elder client says to the nurse, “I just don’t get enough sleep anymore,” the best response by the nurse would be:

1. “It’s common for older adults to feel like they don’t get enough sleep.”
2. “When you get older you don’t spend as much time in REM sleep, so you awaken still feeling tired.”
3. “You probably are waking up frequently during the night. That can make you feel more tired.”
4. “Tell me about your routine, when and where you sleep, and how things are at home.”

(4) In order to determine whether a more serious condition exists, such as sleep apnea, depression, or cognitive impairment, the nurse needs more information. Daily activity, environmental conditions, and sleeping patterns can all affect the quality of sleep. Option 4 is the best response. It is an open form of communication, and the nurse will gain valuable information to further assist the client. Option 1 is true, but to say this to the client demeans their concern and doesn’t lead the conversation into greater detail. Option 2 is also a correct statement and may be used in time to explain why the elder is still feeling tired. But, first the nurse needs to gather more information. Option 3 is also true. Elders do wake more frequently and get fewer hours of extended sleep. That may not make the elder tired as it could still constitute rest if they continue to lie in bed, listen to music, or engage in other restful thoughts.

**29.** All of the following characteristics would indicate to the nurse that an elder client might experience undesirable effects of medicines except:

1. increased oxidative enzyme levels.
2. alcohol taken with medication.
3. medications containing magnesium.
4. decreased serum albumin.

(1) Oxidative enzyme levels decrease in the elderly, which affects the disposition of medication and can alter the therapeutic effects of medication. Alcohol has a smaller water distribution level in the elderly, resulting in higher blood alcohol levels. Alcohol also interacts with various drugs to either potentate or interfere with their effects. Magnesium is contained in a lot of medications elder clients routinely obtain over the counter. Magnesium toxicity is a real concern. Albumin is the major drug-binding protein. Decreased levels of serum albumin mean that higher levels of the drug remain free and that there are less therapeutic effects and increased drug interactions.

**30.** In which of the following maternal conditions should the nurse anticipate a cesarean section?

1. partial placenta previa
2. slow progression of labor
3. placental abruption
4. history of genital herpes

(3) Placental abruption is a medical emergency requiring surgical intervention. A woman with a partial placenta previa can still have a vaginal birth. If it is a complete placenta previa, then a c-section is indicated. As long as labor is progressing, even slowly, the woman is not fatigued, and there is not fetal distress, labor is allowed to continue. Failure to progress at all is an indication for a c-section. Active genital herpes, not a history of, is an indication for a c-section.

**31.** Which of the following clinical manifestations would be most significant when assessing a woman who has given birth within the last 12 hours?

1. lochia rubra
2. fundal height above the umbilicus
3. perineal edema
4. vaginal ecchymosis

(2) Immediately after birth, the level of the uterus is midway between the symphysis pubis and the umbilicus. Within 6–12 hours it rises to the level of the umbilicus. If the nurse's assessment revealed a fundal height above the umbilicus, this would be concerning because the woman would be at increased risk of uterine hemorrhage. Lochia rubra is the normal vaginal discharge the first 3–4 days after birth. Perineal edema and vaginal ecchymosis (bruising) are normal findings in the early postpartal period.

**32.** Which of these physical findings in a woman who has given birth within the last 24 hours should a nurse report to the physician?

1. temperature of 100.4°F (38°C)
2. pulse rate of 55
3. white blood cell (WBC) count of 25,000
4. elevated blood pressure

(4) A decrease in blood pressure after birth indicates the body's attempt to readjust to decreased intrapelvic pressure. An increase in blood pressure, especially if combined with headache, could signal pregnancy-induced hypertension requiring further evaluation and should be reported to the physician. A temperature up to 104°F is not concerning within the first 24 hours after delivery and may occur as a result of the exertion and dehydration associated with labor. Bradycardia the first 6–10 days after delivery is normal and may be caused by decreased cardiac effort and decreased blood volume as well as other factors. A nonpathologic leukocytosis often occurs after delivery with WBC counts ranging from 25,000–30,000.

**33.** A postpartum woman has been given instructions on how to care for her perineum. Which of these statements, if made by the client, would indicate that the instructions were correctly understood?

1. "I don't want to drink so much water so that I won't have to go to the bathroom and wipe my bottom as often."
2. "Would you ask my doctor when he is going to remove my episiotomy stitches?"
3. "Would you get me some ice to put on my episiotomy?"
4. "I'm worried that the sitz bath will get my stitches wet and that they will come out."

(3) Applying ice to the perineum can provide comfort and relief of edema secondary to the birth process. Fluids should be increased during the postpartum period to avoid constipation, which can contribute to hemorrhoids, which can lead to perineal pain. Episiotomy stitches dissolve and do not need to be removed. In some instances surgical glue is used, and there are no stitches. A sitz bath promotes healing and provides for comfort. It will not cause stitches to come out.

**34.** The nurse has assessed the amount of lochia on a perineal pad. The lochia has left less than a 6-inch stain on the peripad within 1 hour. The nurse correctly documents the amount of lochia as:

1. scant.
2. light.
3. moderate.
4. heavy.

(3) A moderate amount of lochia is defined as less than a 6-inch stain on a peripad within 1 hour. Scant lochia is defined as blood only on the tissue when wiped or less than a 1-inch stain on a peripad within an hour. Light lochia leaves less than a 4-inch stain on a peripad within an hour. Heavy lochia means the peripad is saturated within 1 hour.

**35.** All of the following strategies should be utilized by the postpartum woman to prevent thromboembolism except:

1. ambulate early.
2. use the knee gatch on the bed.
3. avoid pressure behind the knees.
4. do not cross her legs when sitting.

(2) Use of the knee gatch should be avoided as it contributes to pressure behind the knees and decreased venous return. Both of these contribute to the development of thromboembolism. All the other options are appropriate self-care measures to prevent thromboembolism.

**36.** When a postpartum woman has successfully attached to her baby, the nurse should expect the client to demonstrate which of these behaviors?

1. The mother holds her baby close to her body and strokes its face.
2. The mother asks to sleep during the night and for the nurses to feed the baby.
3. Every time the nurse enters the room, the baby is in the isolate at the foot of the bed.
4. The mother asks the nurse why the baby cries when she holds it.

(1) Successful early attachment is often first evidenced by the mother holding and examining her newborn; including holding it close to her body and stroking its face. If the mother asks the nurses to feed the baby and does not attend to it at night that could be an indication that she has not attached to the baby and will have trouble providing care upon discharge. If the mother is ill or extremely fatigued, she may ask for help, but the request should always be evaluated by the nurse in relation to attachment. Having the baby constantly at the foot of the bed and not being held is an indication that attachment has not occurred. The mother may be having ambivalent feelings about her baby, and further evaluation is warranted. If the mother perceives that the baby does not respond to her parenting efforts, then failure to attach can occur. Again, further evaluation is warranted.

**37.** Which of the following strategies should the nurse suggest to the postpartum woman who wishes to suppress lactation?

1. "Stand in the shower and allow the water to flow over your breasts. It will relieve some of the pressure."
2. "Be sure to wear a supportive, well-fitting bra during the day time when you are up and active."
3. "Apply ice packs to each axillary area for 20 minutes four times a day."
4. "Apply a heating pad to your breasts for 10 minutes as you need to for comfort."

(3) Applying ice packs to each axillae for 20 minutes four times a day is useful in relieving discomfort, especially if engorgement occurs. This practice should begin soon after birth. When she showers, the mother should be advised to let the water run over her back, not her breasts, to avoid stimulation that will promote milk production. A well-fitting supportive bra should be worn continually for 5–7 days, starting within 6 hours of birth. Heat application to the breasts should be avoided as it increases milk production and delays suppression of lactation.

**38.** When a woman is receiving postpartum epidural morphine, the nurse should plan to observe for which of the following side effects to occur within the first three hours?

1. nausea and vomiting
2. itching
3. urinary retention
4. somnolence

(2) A side effect of postpartum epidural morphine is the onset of itching within 3 hours of injection, lasting up to 10 hours. Nausea and vomiting may occur 4–7 hours after injection. Urinary retention is a side effect of postpartum epidural morphine but would not be assessed as such within the first three hours. Somnolence is a rare side effect.

**39.** The teaching plan for a postpartum client who is about to be discharged should include which of these instructions?

1. “It is normal for your breasts to be tender. You should call the doctor if you also have redness and fatigue.”
2. “Because your baby was delivered vaginally, you may have to urinate more frequently.”
3. “It is normal to run a low-grade temperature for a few days. If it goes over 100°F call your doctor.”
4. “Be sure to call your doctor if your vaginal discharge becomes bright red.”

(4) The vaginal discharge after birth is called lochia and changes from red (rubra) to serosa (clear) on the third postpartum day. If it returns to red or contains clots that could signal impending hemorrhage or infection, the physician should be notified. It is not normal for the breasts to be tender. If the breasts become engorged, they may be tender, and the mother may need to be given additional instructions on breast care. Tenderness, redness, and fatigue are clinical manifestations of mastitis and should be reported to the physician. A woman should void in normal patterns and frequency after birth. Increased frequency is a sign of a urinary tract infection and should be reported to the physician. By the time of discharge, the temperature should be normal. Elevations should be reported to the physician.

**40.** When a nursing mother has soreness on the underside of the nipple which of these causes should the nurse assess?

1. The infant is grasping the nipple only and not including the areola.
2. The nipple may be entering the infant’s mouth at an upward angle.
3. The infant’s bottom lip is being tucked in while nursing.
4. Negative pressure is being created because the infant is falling asleep.

(3) When a nursing mother’s nipples are sore on the underside, it usually because the infant is tucking in their bottom lip while nursing, causing a friction burn. If the infant is not opening his/her mouth wide enough to include the areola as well as the nipple, the mother will complain of cracked or tender nipples at the base. If the nipple enters the infant’s mouth at an upward angle, it rubs against the roof of the mouth, causing the nipple to have an injured tip that may be bruised, scabbed, or blistered. If the infant falls asleep while nursing, then negative pressure is created and soreness follows.

**41.** A woman who has just delivered a baby states to the nurse, “I hope my mother is proud of me and how I take care of my baby.” The nurse should recognize this as evidence of attaining which of the following maternal roles?

1. anticipatory stage
2. formal stage
3. informal stage
4. personal stage

(2) The formal stage begins when the infant is born and is characterized by the mother caring about how others expect her to act. Their guidance is still important to her. The anticipatory stage occurs during pregnancy; in this stage the pregnant woman will look to her mom and others as role models of what it means to be a good mother. The informal stage begins when the woman starts making her own choices about mothering and what works well for her. The personal stage is characterized by the woman being confident in her parenting skills and is the final stage in maternal role attainment.

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

1. emotional support to help the family deal with feelings of guilt about the infant’s condition
2. administration of MICRhoGam to the woman within 72 hours of delivery
3. administration of Rh immune globulin to the newborn within 1 hour of delivery
4. lab analysis of maternal Direct Coomb’s

(1) If a woman is sensitized to the Rh factor, it poses a threat to any Rh-positive fetus she delivers. The nurse will need to provide emotional support to help the family deal with the infant's condition, which may involve a host of conditions that could lead to death or marked neurologic damage. RhoGam is never given to a woman already sensitized. If not previously sensitized, MICRhoGam (a smaller dose of Rh immune globulin) is given after an abortion or ectopic pregnancy to prevent sensitization. If not sensitized, RhoGam is given to the woman within 72 hours of delivery. Rh immune globulin is never given to the newborn. To determine whether sensitization has occurred, an Indirect Coomb's is drawn on the mother to measure the number of Rh-positive antibodies. This would be done if there was no prior sensitization.

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

1. Make a referral for grief counseling.
2. Allow the woman to see her baby initially and then discourage further visits.
3. Provide opportunities for the woman to express her feelings.
4. Inform the woman she has the right to change her mind about relinquishment.

(3) Most women who relinquish their infants at birth have come to that decision with a great deal of love and pain. They have made plans in advance. The nurse needs to first provide them with opportunities to express their grief, loneliness, guilt, and any other feelings. A referral for grief counseling may be appropriate if there is no other support system or the mother indicates she would like assistance with working through her grief. If the nurse assesses abnormal grief process, a referral would also be appropriate. The mother has probably already made a decision about whether or not she wants to see her baby. The nurse should ask her; if she requests to see the infant, the nurse should make arrangements for that to happen. Often seeing the baby aids in the grief process. Until relinquishment occurs, this is the mother's baby, and she should be allowed to see it as often as she wants or requests it. The mother does have the right to change her mind until final legal arrangements are made. But to suggest to her she has this option leaves her to think that the nurse thinks she shouldn't relinquish her baby.

**44.** A postpartum woman is receiving uterine stimulants. The care plan should include which of these measures?

1. Count the number of peripads used per shift.
2. Explain to the woman that uterine cramping should resolve.
3. Monitor the blood pressure and pulse every 15 minutes for the first hour.
4. Assess the fundus when two hours have passed since administration.

(3) Loss of blood from lack of the uterus contracting can lower the blood pressure. The blood pressure should be assessed every 10–15 minutes for the first 1–2 hours after administration and then every hour until stable. The peripads should be weighed, not counted, to estimate blood loss. Because uterine stimulants cause the uterus to contract, uterine cramping is an expected effect of the drug. Pain medication should be administered as needed. In addition to checking the blood pressure every 10–15 minutes the first 1–2 hours after administration, the fundus should also be checked to be sure the uterus is contracting. If it remains atonic, then fundal massage should be done by the nurse. To wait two hours before checking the fundus is too long.

**45.** Which of the following clinical manifestations should alert the nurse to the potential for development of postpartum depression?

1. multiparity
2. planned pregnancy
3. lack of social support
4. positive body image

(3) Lack of social support is a risk factor for the development of postpartum depression. Primiparity, not multiparity, is a risk factor for the development of postpartum depression. Postpartum depression also seems to be more severe in primiparas than in multiparas. If the mother is ambivalent about maintaining the pregnancy, then she is at risk for depression. Women who plan their pregnancies would not have the ambivalence about maintaining the pregnancy. Women who are dissatisfied with themselves or have a poor body image are at greater risk for developing postpartum depression.

**46.** Within the first 5 minutes of life, a newborn has a heart rate of 120, has irregular and slow respirations, is inactive with flexion of the extremities, has generalized pink color with blue extremities, and has a vigorous cry. The nurse should give the infant an Apgar score of:

1. 3.
2. 5.
3. 7.
4. 9.

(3) Apgar Score is used to assess the state of health and transition to extrauterine life of newborns at 1 and 5 minutes after birth. A score of 0, 1, or 2 is given to the infant in 5 areas. This infant would receive a 2 for heart rate, 1 for respiratory effort, 1 for muscle tone, 1 for color, and a 2 for a vigorous cry. The total score is 7. To receive a score of 3 would suggest that the infant is at risk for surviving; a score of 5 indicates probable developmental difficulties. A score of 9 represents excellent transition to extrauterine life.

**47.** When assessing a newborn whose mother consumed alcohol during the pregnancy, the nurse would assess for which of these clinical manifestations?

1. wide-spaced eyes, smooth filtrum, flattened nose
2. strong tongue thrust, short palpebral fissures, simean crease
3. negative Babinski sign, hyperreflexia, deafness
4. shortened limbs, increased jitteriness, constant sucking

(1) The nurse should anticipate that the infant may have fetal alcohol syndrome and should assess for signs and symptoms of it. These include the characteristics listed in choice 1. Choice 2 includes signs and symptoms of Down syndrome, not fetal alcohol syndrome. Choice 3 includes neurologic signs that have no relation to each other or to fetal alcohol syndrome. Choice 4 includes unrelated findings. Shortened limbs can be genetic or teratogenic, increased jitteriness may be a sign or symptoms of metabolic disease or narcotic exposure, and constant sucking may be a sign or symptom of a narcotic-addicted baby.

**48.** Which of the following descriptions accurately describes the transition from fetal to newborn circulation?

1. Closure of the ductus venosus forces perfusion of the liver.
2. When the ductus arteriousus closes, the blood flow is redirected from the pulmonary into the aorta.
3. Decreased pulmonary resistance and increased pulmonary blood flow cause closure of the foramen ovale.
4. Clamping of the umbilical cord causes a decrease in aortic blood pressure and increase in venous pressure.

(1) After the umbilical cord is clamped, there is a redistribution of blood. The liver had largely been bypassed in fetal circulation via the ductus venosus. When the cord is clamped, it causes closure of this bypass and forces perfusion of the liver. The foramen ovale closes as a result of increased pressure in the left atrium, which comes about because of the increased systemic pressure and decreased venous pressure when the cord is clamped. This decreases the pressure in the right atrium. At the same time, pressure in the left atrium is increased because of increased pulmonary flow and pulmonary venous return to the left atrium. The change in pressure causes the foramen ovale to close. Clamping of the umbilical cord causes an increase in aortic blood pressure and a decrease in venous pressure.

**49.** The nurse is teaching the new parents how to prevent heat loss in their newborn. The nurse suggest the parents should place the crib in the middle of the room instead of against an outside wall. This intervention will prevent heat loss by:

1. convection.
2. radiation.
3. evaporation.
4. conduction.

(2) Radiation heat loss occurs when heat is transferred from the infant's body to cooler surfaces, such as outside walls. Convection heat loss occurs when heat is lost from the body to cooler air currents. This can occur when air passes over an unclothed infant, leaving the infant in front of a window air conditioner, and so on. Evaporation occurs when heat is lost because water is converted to a vapor. Examples of this are at bath time or when the infant is first born and still wet from amniotic fluid. Conduction heat loss occurs when an infant is directly exposed to a cooler surface such as being laid on a cold examining table or being handled by cold hands.

**50.** While assessing a 2-day-old newborn, the nurse notes jaundice. The total serum bilirubin level is 15mg/dL. The physician orders phototherapy. The nurse knows that the phototherapy is being successful if:

1. the infant passes loose stools.
2. the jaundice around the eyes begins to disappear.
3. the infant has diminished reflexes.
4. the total serum bilirubin level decreases 1–2 mg/dL within 4–6 hours.

(4) Intensive phototherapy (the application of phototherapy lights) should cause a decrease in total serum bilirubin levels of 1–2 mg/dL within 4–6 hours. If this doesn't happen, the infant may become a candidate for an exchange transfusion. An effect of phototherapy is an increase in the number of loose stools the infant may pass. This can indicate that the bilirubin is being excreted, but the laboratory results are the most quantitative method for determining the level of success of the phototherapy. If the jaundice around the eyes begins to disappear with phototherapy, it means the eye patches are allowing too much light to enter and better eye protection is needed. Diminished reflexes can be a sign of increasing neurotoxicity for increasing bilirubin levels and would not indicate success of phototherapy.

**51.** A 12-hour-old infant is jaundiced and has a total serum bilirubin level of 12 mg/dL. The nurse should recognize this as indicative of:

1. normal physiologic jaundice of the newborn.
2. pathologic jaundice.
3. breastmilk jaundice.
4. jaundice of prematurity.

(2) Pathologic jaundice is characterized by a rise in the total serum bilirubin within the first 24–36 hours of life and may be consistent with an ABO incompatibility. Normal physiologic jaundice of the newborn occurs after the first 24 hours of life and peaks within 3–5 days. Breastmilk jaundice occurs within the first week of life and peaks at 2–3 weeks of age. Premature infants should not experience jaundice within the first 24 hours of life. Any adjustments for prematurity come in the total serum bilirubin levels. For premature infants, levels above 10 mg/dL are considered elevated with peak levels between 5–7 days.

**52.** When assessing a newborn the nurse notes that occasionally a deep red color develops on one side of the newborn's body, and the other side remains pale. The duration of this finding is 10 minutes. The nurse documents this as:

1. acrocyanosis.
2. mottling.
3. harlequin sign.
4. nevus flammeus.

(3) The skin findings in this question are consistent with the Harlequin sign, also known as the clown sign. It is caused by a vasomotor disturbance and typically lasts from 1–20 minutes. They are clinically insignificant. Acrocyanosis is the bluish discoloration of the hands and feet and is clinically insignificant for the first 2–6 hours after birth. Mottling is the lacy pattern seen on the skin caused by dilated blood vessels. It is caused by general circulation fluctuations and can be related to chilling or prolonged apnea. Further assessment is required. A nevus flammeus is a port-wine stain, typically appearing on the face. It is red-to-purple in color, does not fade with time, does not blanch, and is sharply demarcated. If a nevus flammeus accompanies other neurologic symptoms, there is a concern of Sturge-Weber syndrome.



**53.** Because a newborn has a cephalhematoma, the nurse should expect to identify which of the following clinical manifestations?

1. a slightly edematous area of the scalp that crosses suture lines
2. an increase in size when the newborn cries
3. finding present since birth
4. physiologic jaundice

(4) Physiologic jaundice is a common finding in newborns with cephalhematoma. This is caused because extra red blood cells are destroyed inside the cephalhematoma. Cephalhematomas do not cross suture lines; Caput Succedaneums do cross suture lines. Cephalhematomas do not increase in size when the infant cries; a Caput Succedaneum does increase in size when the newborn cries. Caput Succedaneums are present at birth, but it takes 1–2 days for Cephalhematomas to appear.

**54.** Which of these clinical findings would be most significant when assessing a newborn with a suspected cardiac defect?

1. a wide difference in blood pressure between upper and lower extremities
2. a low-pitched, musical murmur heard best to the right of the apex
3. an apical heart rate of 160 that increases with respiration
4. episodic apnea without color or heart rate changes

(1) A wide difference in blood pressure between the upper and lower extremities and/or absent or decreased femoral pulse is an indication of coarctation of the aorta. A low-pitched murmur, musical in quality and heard best to the right of the apex is a common murmur heard in newborns. Ninety percent of all murmurs are transient and considered normal. Normal newborn heart rates range from 120–160 beats per minute but can be as high as 180 beats per minute. A normal deviation is an increase in heart rate with inspiration. Brief periods of apnea or episodic breathing is a normal phenomena of newborns and is not a concern if there is no color change or associated heart rate changes.

**55.** An infant is being assessed within one hour of birth for gestational age. The nurse notes an absence of vernix caseosa. This finding is consistent with:

1. a premature infant.
2. a term infant.
3. a postmature infant.
4. small for gestational age infant.

(3) Absence of the vernix caseosa causes skin desquamation and is commonly seen in infants of greater than 42 weeks gestation. Premature infants have thin and translucent skin with prominent veins on the abdomen. Term infants have increased amounts of subcutaneous tissue, and the skin is more opaque in appearance. Small gestational-for-age infants would have their skin evaluated based on their gestational age, not size.

**56.** When a newborn receives Vitamin K<sub>1</sub> Phytonadione (Aquamephyton), which of the following measures should the nurse include?

1. Give the medication prior to circumcision.
2. Inject the medication SQ (Subcutaneously) within 6 hours of birth.
3. Administer the Vitamin K orally.
4. Store the Vitamin K in a well-lighted area.

(1) Vitamin K is given to the newborn as prophylaxis and treatment of hemorrhage. Since circumcision is a surgical procedure and can be associated with blood loss, the infant should have received the Vitamin K prior to circumcision. The medication is injected either IM or SQ within the first hour of life. Oral Vitamin K has not been shown to be effective and is not currently recommended in the United States. Aquamephyton should be protected from light, not exposed to or stored in light.

**57.** When administering Erythromycin Ophthalmic Ointment (Ilotycin Ophthalmic) to a newborn, which of the following nursing considerations should the nurse incorporate?

1. Wipe away any excess medication after 2 minutes.
2. Instill a narrow ribbon about ½-inch long.
3. Irrigate the eyes after instillation.
4. Massage the eyelids gently after administration.

(4) The eyelids should be massaged gently to distribute the ointment. Any excess medication should be wiped away after 1 minute. The medication should be instilled, using a narrow ribbon about ¼-inch long. The eyes should not be irrigated after instillation.

**58.** The teaching plan for a newborn that has undergone circumcision should include which of these instructions?

1. “You should call your doctor if the penis becomes covered with a whitish yellow exudate.”
2. “The use of an ointment such as A & D will keep the diaper from adhering to the penis.”
3. “Use soap and water to keep the penis clean.”
4. “If a plastibell is used, it should fall off after 8 days.”

(2) The use of A & D ointment, petroleum jelly, or an antibiotic ointment will keep the penis from adhering to the diaper. These ointments should not be used if the circumcision was done with a plastibell. A whitish yellow exudate is formed because of normal granulation of tissue after the circumcision and should not be removed. It should be present for about 2–3 days. The use of soap should be avoided until the circumcision is healed. Warm water can be gently squeezed from a cloth over the penis to assist in removing any urine or feces. A plastibell normally falls off on its own within 8 days. After that time, it will have to be manually removed.

**59.** Which of these statements, when made by the nurse, is most effective when communicating with a 4-year-old?

1. “Tell me where you hurt.”
2. “Other children like having their blood pressure taken.”
3. “This will be like having a little stick in your arm.”
4. “Anything you tell me is confidential.”

(1) Four-year-olds are egocentric and interested in having the focus on themselves. They will not be interested in what it feels like to other children. Preschoolers are concrete thinkers and would literally interpret any analogies so they are not helpful in explaining procedures. Assurance of confidential communication is most appropriate for the adolescent. In addition, confidentiality is not maintained if the child plans to harm themselves, harm someone else, or discloses abuse.

**60.** While performing a physical assessment on a 6-month-old, the nurse observes the infant has head lag. Which of the following nursing actions should the nurse do first?

1. Ask the parents to allow the infant to lay on its stomach to promote muscle development.
2. Notify the physician of the need for a developmental or neurological evaluation.
3. Document the findings as normal in the nurse’s notes.
4. Explain to the parents that their child will likely be mentally retarded.

(2) Head lag should be completely resolved by 4 months of age. Continuing head lag at six months of age requires further developmental or neurological evaluation. Laying the infant on its stomach will indeed promote muscle development of the neck and shoulder muscles, but because of the age of this child a referral is still the first action. These findings are not normal for a 6-month-old. Significant head lag can be seen in infants with Down Syndrome, hypoxia, and neurologic and other metabolic disorders. Some of those disorders may have mental retardation as a component. However, this child needs to have the referral to determine the cause of the head lag first.

**61.** A preschooler has successfully completed the test item “counts 5 blocks” on the Denver II. The nurse correctly interprets this pass as evidence of which of the following developmental concepts?

1. centration
2. causality
3. nonreversibility
4. conservation

(4) The ability to move 5 blocks to a piece of paper and state there are 5 blocks on the paper is evidence the preschooler has the ability of conservation. This concept refers to the fact that the quantity of something doesn’t change just because the shape, contour, and so on has changed. Five blocks are still 5 blocks whether they are lying beside the paper, stacked on the paper, or moved to the paper. Centration is the ability to concentrate on one feature of a situation while neglecting all other aspects. Causality is based on the sequence of events, one event ordinarily following another. Nonreversibility refers to the inability of preschoolers to reverse their operations. They are only able to think forward, not retrace or reverse their thought processes.

**62.** The parents of a 2-year-old ask the nurse how they can teach their child to quit taking toys away from other children.

Which of the following statements by the nurse offers the parents the best explanation of their child’s behavior?

1. “Your child is egocentric. He believes the other child would want him to have the toy.”
2. “Your child is showing negativity. He doesn’t want other children to have the toys he wants.”
3. “Your child is demonstrating magical thinking. He believes he can made the other child want him to play with the toy.”
4. “Your child is engaging in domestic imitation. He is doing what he has seen other children do.”

(1) A 2-year-old child is very egocentric. They believe everything and everyone is concerned about them. He believes the other child would want him to have the toy. This is different than believing he can make other kids want him to have all the toys (magical thinking means thinking something can make it happen). Early preschoolers are very negative, but this is expressed by near constant refusal of any requests made to them. Domestic imitation does occur in preschool age but refers to the imitation of household chores and roles performed by adults, not imitating behaviors of other children.

**63.** Which of the following infant behaviors demonstrates the concept of object permanence?

1. The infant cries when his mother leaves the room.
2. The infant looks at the floor to find a toy he was playing with that was dropped.
3. The infant picks up another toy after the one he was playing with rolls under the couch.
4. The infant participates in a game of patty-cake.

(2) Object permanence occurs after the infant learns that something/someone still exists even though they might not be able to see it/them. This develops at 9–10 months of age. If the infant cries when his mother leaves the room, it may show he believes she is no longer in the house because he can’t see her. If an infant picks up another toy after the one he is playing with rolls under the couch, and the infant fails to look for it, he believes the toy that rolled under the couch no longer exists. Patty-cake is a game infants engage in but has nothing to do with object permanence. An infant game that does show object permanence is peek-a-boo. In this game, the infant continues to hunt for the hidden face because he believes it is still there.

**64.** The nurse is assessing a 12-month-old who weighed 7 pounds at birth. Which of the following measured weights today is most likely related to normal development?

1. 12 pounds
2. 21 pounds
3. 35 pounds
4. 48 pounds

(2) A good guide to adequate infant weight is that the birth weight doubles by 6 months of age, triples by 1 year and quadruples by 2 years of age. A 12-month-old who weighed 7 pounds at birth should weigh at least 21 pounds ( $3 \times 7\text{lbs}$ ). All the other measurements are too little or too much.

- 65.** The parents of an 18-month-old tell the nurse that he says “no” to every request. When they scold him, he is sad and wants to be held. The nurse teaches the parents these behaviors are indicative of:
1. interrupted moral development.
  2. the need for more attention.
  3. normal behavior for his age.
  4. behavior that needs further evaluation.

(3) This is normal behavior for an 18-month-old. They actively engage in negativism, which means they will say “no” even if they want to do something. Theorist generally agree that 18-month-olds have not yet begun moral development. When preschoolers begin moral development they “behave” to avoid punishment, not because they understand the difference between “bad” and “good.” This behavior is normal so it does not need further evaluation.

- 66.** Which of the following characteristics should the nurse recognize as true cultural differences in growth and development in children 1-year-old?
1. Mexican-American children have greater stature than Anglo children.
  2. Thigh circumference is greater in Anglo children than in Mexican-American children.
  3. The Anglo children have less risk of low-birth-weight babies than Mexican-American children.
  4. The Mexican-American child has greater weight for length than the Anglo child.

(4) The Mexican-American child has greater weight for length than the Anglo child. Anglo children have greater stature than Mexican-American. Mexican-American children have greater thigh circumference than Anglo children. Mexican-American children have less risk of being low birth weight than Anglo children.

- 67.** Which of the following actions should the nurse take to assess for the Landau reflex?
1. Suspend the infant in a horizontal, prone position and flex the head.
  2. Thrust the infant downward from a horizontal position.
  3. Place the infant horizontally and support him under the abdomen.
  4. Stroke one side of the spinal column while the baby is on his/her abdomen.

(1) The Landau reflex appears at approximately 3 months and disappears between 12–24 months. The infant should be suspended horizontally in a prone position. The head should be flexed against the trunk. This causes the legs to flex. The parachute reflex appears at approximately 7–9 months and persists indefinitely. It is assessed by suddenly thrusting the infant downward from a horizontal position, which causes the hands and fingers to extend forward and spread as if to protect from a fall. The trunk incurvation reflex is present in utero, seen the third or fourth day of life and disappears by 2–3 months of age. It is assessed by stroking one side of the spinal column while the infant is on his abdomen. This causes the infant to make crawling motions, lift her head, and curve her trunk toward the side that was stroked.

- 68.** The nurse is assessing the language development of a 2-year-old. Which of the following characteristics would cause the nurse concern?
1. The child obeys simple commands.
  2. The child points to what they want.
  3. The child has 60–75 percent understandable speech.
  4. The child speaks in two to five word sentences.

(2) A 2-year-old child should be able to simply state what they want. Younger children will point because they don’t have sufficient language development. Two-year-olds are able to obey simple commands, speak in two to five word sentences and have speech 60–75 percent understandable. These are normal findings and would not cause the nurse concern.

**69.** Which of the following toddler behaviors would demonstrate to the nurse the toddler is mastering autonomy?

1. Asks for a different story every night at bedtime.
2. Watches others perform tasks and says “You do it.”
3. Says “yes” to a request and then does it.
4. Shows interest in toilet training.

(4) Being autonomous is the ability to gain self-control, including over body functions such as toilet training. Toddlers are very ritualistic and gain a sense of security and control through rituals. Toddlers will say “Me do it” and have great pride in their attempts to carry out tasks themselves. One of the hallmarks of autonomy for a toddler is discovering the power to say “No,” even if they later do what was asked of them. It gives them a sense of increasing control over their situations.

**70.** Which of the following statements is true regarding the growth and development of the musculoskeletal system of young adults?

1. Skeletal growth is not complete until age 30.
2. Peak muscle strength with maximum potential occurs.
3. Muscle growth is complete by age 25.
4. The vertebrae attains adult distribution of red marrow by age 20.

(2) Peak muscle strength with maximum potential occurs between 19–30 years of age, coinciding with the age of young adulthood. Skeletal growth is complete by age 25; muscle growth is complete by age 30; and the adult distribution of red marrow in the smaller leg bones, sternum, pelvic bones, and vertebrae is attained by age 25.

**71.** The parents of a preschooler ask the nurse how they should talk with their preschooler about the death of a grandparent. The nurse’s best response is:

1. explain that the grandparent is only sleeping.
2. tell the child their grandparent is in heaven.
3. assure the child their grandparent loved them very much.
4. answer the child’s questions in simple physical and biologic terms.

(4) Answering questions about death will in part depend upon the family’s beliefs about the death process and what happens after death. Small children such as preschoolers think about death in illogical, egocentric, and primitive ways. They will care that they won’t get to see or hug the grandparent again and may ask questions about how their grandparent breathes or what do they eat. Responding to each question in simple terms without abstractions or elaborations is the best response. Telling the child that the grandparent is sleeping will give them hope the grandparent will awaken and is not truthful. Family’s may believe the grandparent is in heaven and in such cases it is appropriate to tell the child this, but questions will still arise about the grandparent and what it is like to be dead. So, that option only prolongs and broadens the questions. It is necessary to assure the child they were loved by the grandparent along with assurances the child will not be abandoned, but questions will still come.

**72.** An infant has been hospitalized and clings to the parent when the parent tries to leave. The nurse interprets this behavior as being which of the following stages of separation anxiety?

1. protest
2. despair
3. detachment
4. loss of control

(1) Separation anxiety is largely a reaction of hospitalized infants and toddlers. It is characterized by the infant crying, screaming, searching for the parent with their eyes, clinging to the parent, and avoiding or rejecting contact with strangers.

Despair is manifested by inactivity, withdrawing from others, depression, noninterest in the environment, and noncommunication. Detachment occurs when the infant shows increased interest in their surroundings, interacts with strangers, and appears happy. Loss of control is an entirely different category of responses of children to hospitalization.

**73.** A toddler verbally attacks the nurse when she enters his hospital room. A nurse should recognize this as indicative of:

1. the toddler's response to pain.
2. loss of control related to being in the hospital.
3. insecure attachment to his parents.
4. separation anxiety.

(4) Toddlers express separation anxiety by verbally attacking strangers, physically attacking them, attempting to escape, or forcing their parents to stay. When in pain toddlers are anxious, respond negatively to restraint and parental separation, grimace, clench their teeth, and open their eyes wide. Toddlers experience loss of control as negativism, regression, and loss of routine. Insecure attachment to the parents would be evidenced by no response to parental absence and acceptance of the nurse without protest.

**74.** Which of the following nursing actions would be most successful to assist a preschooler in adjusting to hospitalization?

1. Assign the same nurse to care for the preschooler each shift.
2. Explain to the child they must wear hospital pajamas.
3. Teach the parents that sibling visitation will only make the child miss them more.
4. Suggest the parents bring in a new toy for the child to play with.

(1) Preschoolers respond better to routine, and having the same nurse each shift will provide a sense of control and aid in adjusting to hospitalization. Allowing the child to wear their own pajamas will give them more control than forcing them to wear hospital pajamas. Visitation by siblings reassures the child and the siblings that the preschooler is OK and allows for the familiarity of routine. Hospitalized children gain comfort from familiar toys, not new toys.

**75.** The nurse is providing anticipatory guidance to the parents of a 3-year-old child. Which of these statements, if made by the parents, would indicate that they correctly understood the guidance?

1. "We will practice having him put his shirt on."
2. "We will start teaching him to brush his teeth."
3. "We will have him practice balancing on one foot for 6 seconds."
4. "We will teach him to hop."

(4) Anticipatory guidance is information given to parents in advance of acquiring a developmental skill to assist parents in helping their child attain that skill. Hopping is a skill not yet acquired by 3-year-olds but one on which they are ready to begin working. Three-year-olds should already be able to put articles of clothing on by themselves and should be able to brush their teeth with assistance, and some will be able to brush their teeth without assistance. Balancing on one foot for 6 seconds is a skill of 4–6 year olds. This child would not yet be ready to begin this.

**76.** The nurse is preparing to administer the Denver II to a preschooler. Which information should a nurse recognize as most essential to interpretation of the results?

1. The preschooler was 6 weeks premature,
2. The parents inform the nurse the child has a fever,
3. The child has never been tested using the Denver II before,
4. The child's height for weight is 75 percent.

(2) The Denver II is a developmental screening test intended for use with well children. When sick, as in having a fever, children tend to regress and do not perform up to their usual level. This could negatively impact the results of the test. The age line is adjusted for prematurity up to the age of 2. By definition a preschooler is over 2 so the fact the child is premature would have no impact on the results of this screening. The lack of previous testing is an indication for testing now but should have no impact on the results. Looking at height and/or weight is a part of routine well child care but has nothing to do with the Denver II.

**77.** When obtaining the health history from the parents of a 7-month-old infant, which information should a nurse recognize as the most concerning related to the infant's gross motor development?

1. The infant rolls over from front-to-back.
2. The infant does not pull to stand.
3. The infant does not have a thumb-finger grasp.
4. The infant does not sit without support.

(4) Infants should be sitting without support by 7 months of age. This would be a cause for concern and further assessment in this case. It is normal for 7-month-olds to roll over. It is normal for infants this age to also have a thumb-finger grasp, but this is a fine motor development, not gross motor. This infant should begin pulling to stand within the next month, but it is not an expected milestone at 7 months.

**78.** Which of these statements, if made by a parent of a 5-year-old, would indicate a need for further evaluation?

1. "My child is able to draw a person with at least six body parts."
2. "My child is able to stack at least eight blocks."
3. "My child knows two colors."
4. "My child is able to throw a ball over handed."

(3) A 5-year-old child should know at least four colors so this child would need further evaluation or retesting. All five-year-olds should be able to draw a six-part person, stack eight blocks, and throw a ball overhanded. This is normal development and not a cause of concern.

**79.** Which of the following statements would be the best for the nurse to use when asking a 3-year-old to perform a task?

1. "Would you like to take your medicine now?"
2. "Which medicine would you like to take first?"
3. "Are you ready for your bath?"
4. "Would you like to help me pick up your toys?"

(2) Three-year-olds prefer autonomy versus shame. Offering them simple choices gives them a sense of control or autonomy. However, they should only be offered choices they really do have. In asking them which medicine they would like to take first, the nurse has not given them a choice to not take the medicine, just which one they want first. The most likely reply to asking them whether they would like to take their medicine now is "no." That is offering them a choice they do not have. Asking them whether they are ready for their bath will again result in a "no" answer because that is how they can achieve a sense of control. Three-year-olds may engage in role playing, helping activities, but again it is phrased as a choice when it is not. A "no" answer is expected.

**80.** When caring for an adolescent with Erythema multiforme, which nursing action would be most effective in assisting the adolescent in meeting the developmental need of peer interaction?

1. Arrange for the adolescent's football team to visit.
2. Ensure that the adolescent knows how to use the hospital phone.
3. Show the adolescent where the teen recreation room is.
4. Allow the adolescent to check out of the hospital for a brief time.

(2) Erythema multiforme is a skin reaction to either viral infections or medication. It can be very disfiguring. As such, adolescents would be reluctant to have their friends or other adolescents see them. Ensuring they know how to use the hospital phone system will allow them to visit with their peers without having their peers see them less than at their best. Having the entire football team see them with erythematous skin eruptions all over their body would have a negative impact in the adolescent's self image. While other adolescents in the hospital may be less threatening to the hospitalized adolescent than their well friends, it would still have a negative impact on their self image to be seen by another adolescent with the skin eruptions of Erythema multiforme. If the purpose of the respite from the hospital is to visit with other teens, the same effect would be had as if they visited the hospital. The adolescent would be seen by their peers as disfigured.

**81.** If a 13-year-old's growth and development are within normal range, which of these behaviors would the nurse expect to identify?

1. a reliance on peer opinion over parental opinion
2. major conflicts over independence and parental control
3. increase in friendships with members of the same sex
4. dating as a romantic pair

(3) Thirteen-year-olds are in early adolescence. Attraction to the opposite sex and/or exploration of relationships with members of the opposite sex does not occur until middle adolescence. Early adolescents value their peer's opinion but have not yet relinquished parental opinion. Peers' opinions become more important in middle adolescence. Major conflicts with independence and parental control develop in middle adolescence, not early adolescence. Dating as a romantic pair occurs in late adolescence. Dating in early adolescence is limited and usually confined to group dating.

**82.** When assessing a child in middle adolescence, a nurse would expect to identify which of these signs?

1. stature at 95 percent of expected adult height
2. appearance of secondary sex characteristics
3. adult maturation of secondary sex characteristics
4. increased growth acceleration in girls

(1) By the end of middle adolescence, stature has reached 95 percent of the expected adult height. Some growth may continue into late adolescence. The appearance of secondary sex characteristics is in early adolescence. Complete adult maturation of the secondary sex characteristics occurs in late adolescence. Growth acceleration in girls increases in early adolescence and decreases in middle adolescence.

**83.** Which of these statements, if made by the parents of a 7-year-old child, indicates correct understanding of their child's expected growth?

1. "My child should gain about 10 pounds per year and grow 1–2 inches per year."
2. "I should call the doctor if my child is still wearing the same size clothes next year."
3. "My child should experience rapid growth the next two years and then slow down."
4. "My child will grow about 2 inches per year and gain approximately 5 pounds per year."

(4) School children grow about 2 inches per year and have a weight gain of approximately 5 pounds per year. A gain of 10 pounds per year would cause the child to be overweight and 1–2 inches would make the child of shorter stature. Determining adequate growth based on the ability to wear the same clothing more than one year is not the best way to measure growth. Some clothing styles allow a child to wear them more than one year. If, however, the parents report that they haven't had to buy their child clothes for 2–3 years in a row, that would be cause for concern. School age children experience continual growth throughout their school years. Growth spurts occur in adolescence.



**84.** The nurse is teaching parents of older school age children about growth differences in late childhood. Which of the following observations would the parents expect to find in their children?

1. The boys will become taller than the girls.
2. Boys have more rapid weight gain for their height.
3. Wisdom teeth develop.
4. Lordosis becomes pronounced.

(2) Between the ages of 10–12 (late childhood), boys growth in stature begins to slow, but they continue to gain weight at the same pace and may actually become obese during this period. Girls in late childhood become taller than the boys. All of their teeth will erupt during childhood with the exception of wisdom teeth. Children in this age group begin taking on the posture of adults and overcome the lordosis of childhood.

**85.** Which of the following behaviors of school age children would most indicate normal play?

1. boys and girls playing basketball together
2. disinterest in joining clubs
3. invention of new games with rigid rules
4. reading a book at recess

(3) School age children become aware of the necessity of rules and become very rigid in their approach to them. They may either make up new games with a variety of complicated rules or even expand on the rules of games they already enjoy playing. School age children tend to play in groups of the same sex. Boys and girls may all be playing basketball, but it would be unusual for them to be playing it together. Joining clubs and other groups of children provides school age children with a sense of belonging. Knowing the rules of the clubs demonstrates to others that they belong. Reading is a recreation for school age children, and many enjoy it. Most read when they do not have the opportunity to join other children at play. Recess is a time of socialization, and reading would not be the activity of choice for most children.

**86.** The nurse observes a group of children playing kickball. A captain of each team has been selected, and each child has been assigned a position in the playing field. She documents in the record her observation of which type of play?

1. solitary
2. parallel
3. associative
4. cooperative

(4) Cooperative play occurs when the play is organized, requires goals, division of labor, and a leader. Solitary play occurs when a child plays alone and usually involves imaginative or studious activities. Parallel play occurs when children play independently next to each other without group involvement. Associative play involves children playing together without the benefit of organization, division of labor, or leadership.

**87.** The nurse hears a 12-month-old child say the word “up” and observes the child then hold her arms up to the parent. The nurse correctly documents in the record that the child engages in what type of speech?

1. holophrases
2. telegraphic
3. overextension
4. receptive vocabulary

(1) Holophrases are the use of a single word that conveys different meanings. In this case the single word “up” conveys to the parents that the child actually wants to be picked up. Holophrases are utilized by children 10–13 months of age. Telegraphic speech occurs 12–26 months and is characterized by short, precise words in 2–3 word combinations. Overextension occurs at 16–20 months of age and is the use of a single word to generalize a meaning based on movement,

texture, size, or shape. For example a “tick-tock” would refer to all clocks, not just a wristwatch. Receptive vocabulary occurs early in life, at 6–9 months, and is the ability of the infant to understand what is being said to them, and they can act on that. For example if asked to point to their nose, they will do so, even if they can’t say “this is my nose.”

**88.** Which of the following statements, when made by a young adult client who has cystic fibrosis, would indicate that the client has at least one minor defining characteristic of body image disturbance?

1. “I’m planning on having a child as soon as possible.”
2. “If I take my enzymes, perhaps I’ll gain a little bit of weight.”
3. “I am so excited to be on the lung transplant list.”
4. “I always go to the doctor right away when I start feeling sick.”

(1) For the client to state they are planning on having a child as soon as possible means they have not accepted the loss of their reproductive ability. Male clients are almost always sterile due to blockage or absence of the vas deferens. Females with CF have great difficulty in conceiving because of the increased mucus secretions in the reproductive tract. Recognizing associated weight loss of CF and the intervention to compensate for that is a move toward healthy body image. To have body image disturbance, there must be a negative perception of the lost function or part. Option 3 is a very positive response and does not indicate a disturbance of body image. The same is true for option 4 in that the client is acknowledging their need for care and taking steps to receive it. This is a positive response and helps prevent body image disturbance.

**89.** A client with Kawasaki Disease has bilateral conjunctivitis, fissured lips, strawberry tongue, and desquamation of the hands. Which of the following nursing measures would be most appropriate to meet the expected outcome of positive body image?

1. Administer immune globulin intravenously.
2. Assess the extremities for edema, redness, and desquamation every 8 hours.
3. Explain to client and family the progression of disease.
4. Assess heart sounds and rhythm.

(3) Teaching the client and family about the progression of the disease includes explaining when the symptoms listed will improve and resolve. That knowledge should help them understand there will be no permanent disruption in physical appearance, leading to a positive body image. Patients with Kawasaki Disease do receive immune globulin intravenously but that is to reduce the incidence of coronary artery lesions and aneurysms. This intervention is linked to body image in that it could be disturbed if cardiac effects were experienced, but option 3 is the most appropriate and direct link to improved body image. It is important for the nurse to assess the extremities for edema, redness, and desquamation every 8 hours in clients with Kawasaki Disease to be able to evaluate treatment and progression of the disease. Results of the assessment can be included in the teaching and may help the client regain a positive body image, but option 3 would be the most appropriate intervention. Heart sounds and rhythm are important assessments to help monitor the cardiac effects of Kawasaki Disease and ultimately impact body image in a positive way but still do not have the immediate or direct effect that option 3 does.

**90.** Which of the following characteristics would the nurse expect to impact the body image of a client newly diagnosed with hemophilia?

1. immobility
2. altered growth and development
3. hemarthrosis
4. altered family processes

(4) Although diagnosis of hemophilia can occur prior to birth through chorionic villus sampling or amniocentesis, it is rare for infants under 6 months of age to experience bleeding problems. Therefore, the long-term effects of hemophilia such as immobility related to contractures and disabling deformities and altered growth and development would not be present in a newly diagnosed client. Hemarthrosis is the acute bleeding into a joint space that is characteristic of hemophilia. It would not have an immediate effect on body image of a newly diagnosed hemophiliac as that client is likely an

infant and unaware of how this impacts their body image. What infants are aware of how their caregivers respond to their needs or lack thereof. These stresses have an immediate impact on how the infant develops trust and how others relate to them because of their diagnosis. So, option 4 is the correct answer.

**91.** When a child with osteosarcoma has a limb amputation, which actions should a nurse take initially to prepare the child for the expected changes in body image?

1. Plan for a visit from another child who is well adjusted to a prosthesis.
2. Immediately help the child learn to care for the stump.
3. Role play with the child how to tell their friends about the amputation.
4. Show the child how it is possible to participate in sports with a prosthesis.

(1) Initially, it is important for the child to see another child who has a prosthesis and is doing well. This allows them to ask questions, to have a preview of what they will look like, and begin to mentally prepare for the amputation. Children should be allowed to gradually learn how to care for the stump. They progress from only looking at the stump briefly, then looking for longer periods, to finally touching the stump. It is important to discuss how to tell their friends about their amputation, and role playing can be beneficial, but this will go more smoothly if they have had the opportunity to meet another child who is doing well under the same circumstances. They can even incorporate that into the role play. For children and adolescents who are active in sports, it is important to show them through videos or physical therapy that participating in sports is still possible. This is not the initial intervention, however, and will require some adjustment before they can think in those terms.

**92.** When a woman has breast cancer and is scheduled for a simple mastectomy, a nurse should anticipate a disturbed body image and include which of the following in preoperative teaching?

1. Explain surgical procedure, including information about preoperative medications, anesthesia, and recovery.
2. Encourage discussion about resuming her life at home and the changes she must make.
3. Explain that she may experience scaling, flaking, dryness, itching, rash, or dry desquamation of the skin after radiation therapy.
4. Discuss how she views her body and the image of herself she has before the surgery.

(4) Because self-image is related to self-esteem and body image, a discussion of the woman's current view and image of herself will establish a baseline and assist the nurse in determining whether a change has occurred. An explanation of the surgical procedure, medications, anesthesia, and recovery are important to decrease anxiety, not manage disturbed body image. The woman will need to consider how her life at home will be impacted and changes she must make as anticipatory coping for changes after her surgery. It will not be as directly related to body image as option 4. Radiation therapy is sometimes done prior to surgery to shrink the tumor before the procedure or after the surgery as adjunct therapy to prevent metastasis. It is more appropriate to have the discussion in option 3 prior to radiation, not before the surgery. In those situations, it may give her a more realistic view of what will happen, thus enhancing her body image.

**93.** After breast reconstruction secondary to breast cancer, a nurse should recognize which of these client outcomes as evidence of a favorable response to nursing interventions for disturbed body image?

1. maintain adequate tissue perfusion
2. demonstrates behaviors that may reduce fears
3. restored body integrity
4. remains free of infection

(3) Woman who have had breast reconstruction surgery report that it has simplified their lives and restored their body integrity. A restored body integrity is an expected outcome for interventions related to disturbed body image. Adequate tissue perfusion is an outcome for risk for injury and risk for infection, not disturbed body image. Demonstrating behaviors that may reduce fears is an outcome for anxiety. Remains free of infection is an outcome for risk for infection.

**94.** When a client with a major burn experiences body image disturbance, which of the following are appropriate nursing intervention classifications?

1. grief work facilitation
2. vital signs monitoring
3. medication administration: skin
4. anxiety reduction

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

**95.** A client with a major burn has been given instructions about a heterograft. Which of these statements, if made by the client, would indicate that the client correctly understood the instructions?

1. “The surgeon is going to take skin from my back and put on my burned leg.”
2. “The skin they are going to put on my burn comes from an animal.”
3. “My graft is going to come from a cadaver.”
4. “They are going to use a bioengineered substance on my burn.”

(2) A heterograft, or xenograft, is skin obtained from an animal, usually a pig. Fresh porcine heterografts are available in some centers but most use frozen heterografts. Skin used from another site on the patient is called an autograft. Grafts from cadavers are called homografts or allografts. Bioengineered substances are used for grafts and are called by their respective trade names or the type of materials from which they are made.

**96.** A client with a major burn tells the nurse they feel like people are staring at them when they wear the tubular support bandages over their graft. The best response by the nurse would be:

1. “Tell me how that makes you feel.”
2. “You only have to wear them for 5–7 days.”
3. “I understand how that would make you feel.”
4. “If you wear the bandages, it will help reduce the scarring.”

(1) Asking the client to tell you how that makes them feel is assisting them to express their feelings and thoughts about people staring at their bandages. Being concerned about how others respond to your appearance is one of the characteristics of disturbed body image, a common nursing diagnosis for clients with major burns. Active listening is a major nursing intervention classification for disturbed body image. It is true they only have to wear the tubular support bandages for 5–7 days but telling them that will not reduce their feelings about being stared at. In addition they will have to wear elastic pressure garments for 6 months to a year. So dealing with their thoughts and feelings will have a more long-term impact. The nurse does not understand how the client feels. Even if the nurse had experienced a major burn personally, the circumstances and individual responses will not be the same. Saying you know how the client feels shuts down further communication. It is also true that the tubular support bandages will help reduce scarring, and ultimately this may help gain acceptance. But the more immediate intervention is active listening.

**97.** When a client with inflammatory bowel disease says to the nurse, “I know I need an ileostomy but I don’t think I could stand to look at myself,” the best response by the nurse would be:

1. “You would feel so much better if you had the surgery.”
2. “I could introduce you to someone else who has an ileostomy.”
3. “Tell me what you think it would look like.”
4. “We would teach you to take care of it gradually.”

(3) Asking the client to tell the nurse what they think the ileostomy would look like is further assessment and the best answer. This lets the client express their feelings and concerns and lets the nurse know whether what the client is thinking is accurate. The nurse would have a basis from which to make other interventions to assist the client in the decision-making process. Telling the client they will feel better may be true but doesn't address their concern of how they will look. If their self view is negative because of the ileostomy, they may prefer to feel ill. One of the nursing interventions to promote a positive body image in this situation would be to teach them gradually how to care for the ileostomy versus expecting them to have total self care immediately. However, that doesn't address the immediate concern of how they will feel because of how it looks. Option 3 is the best answer.

**98.** When assessing a client with Cushing's syndrome, which set of findings would most substantiate a nursing diagnosis of disturbed body image?

1. peptic ulcers, hypokalemia, impotence, and truncal obesity
2. muscle wasting, hirsutism, ecchymosis, and purple striae
3. hypertension, glycosuria, hypernatremia, and osteoporosis
4. weakness, renal calculi, amenorrhea, and polydipsia

(2) All of the symptoms listed in all four options are clinical manifestations of Cushing's syndrome. To consider the nursing diagnosis of disturbed body image, the nurse must assess for those symptoms that will create a negative perception of the function or structure of the body. All of the symptoms listed in option 2 are visible symptoms. Visible symptoms have a more negative impact on body perception. So, option 2 is the most correct answer. In option 1, peptic ulcers and hypokalemia are the least likely symptoms to have a negative impact on body image with impotence and truncal obesity having the greatest negative impact on body image in that list of symptoms. In option 3 there is only one symptom that is likely to have a negative impact on body image and that is osteoporosis. Option 4 contains a list of symptoms that would likely have indirect effects or minor defining characteristics of disturbed body image.

**99.** Which of the following home care strategies would most likely negatively impact the body image of a client with Cushing's syndrome?

1. Provide safety measures to prevent falls.
2. Take medications as prescribed.
3. Wear a medical ID indicating Cushing's syndrome.
4. Have regular health assessments.

(3) All of the strategies listed are included in home care for the client with Cushing's syndrome. Option 3 is the best answer because wearing a medical ID is a visible sign that something is wrong and a constant reminder to the client that they have a loss of body function. Option 1 may enhance body image because it prevents falls that could cause further injury and debilitation. Taking medications as prescribed should enhance body image because it decreases the symptoms present. Having regular health assessments would indicate an enhanced body image as it signals the desire to take care of the body and wanting to keep it at its best.

**100.** When a client wishes to improve the appearance of their eyes by removing excess skin from the face and neck, the nurse should provide teaching regarding which of the following procedures?

1. dermabrasion
2. rhinoplasty
3. blepharoplasty
4. rhytidectomy

(4) Rhytidectomy is the procedure for removing excess skin from the face and neck. It is commonly called a face lift. Dermabrasion involves the spraying of a chemical to cause light freezing of the skin, which is then abraded with sandpaper or a revolving wire brush. It is used to remove facial scars, severe acne, and pigment from tattoos. Rhinoplasty is done to improve the appearance of the nose and involves reshaping the nasal skeleton and overlying skin. Blepharoplasty is the procedure that removes loose and protruding fat from the upper and lower eyelids.

**101.** When teaching a client about home care following cosmetic surgery, all of the following instructions will have a positive impact on the body image except:

1. expect healing to be complete with final results visible within 6 months.
2. avoid picking at crusts or scabs.
3. notify the doctor immediately if there are sign or symptoms of infection.
4. use a 15 or higher SPF sunblock when outdoors.

(1) Healing from plastic surgery may take a year for healing to be complete and the final results visible. Options 2, 3, and 4 are all instructions that should be included for clients having had plastic surgery. If the client picks at crusts or scabs, they may disrupt the healing process and have more scarring. Signs of infection should be reported immediately to the surgeon; if infection occurs, it can have a negative result on the final appearance. Sunblock of 15 SPF or higher is usually prescribed for months and may be recommended for the rest of the client's life.

**102.** A malignant epidermal lesion was removed from a client by curettage followed by electrodesiccation. Which of the following wound descriptions would the nurse expect to identify?

1. white to black appearance, blister formation, eschar formation
2. wound left open to heal, covered by a dressing with topical antibiotics applied
3. edema, necrosis, and tissue sloughing with application of topical antibiotic
4. sutures in place, covered with a hydrocolloid dressing

(2) Curettage is the removal of lesions with a curette and is used to primarily remove benign or malignant epidermal lesions. The curette cuts through soft or weak tissues but not normal tissue. This is followed by electrodesiccation to destroy any remaining malignant cells and to provide hemostasis. The wounds are not closed but left open, topical antibiotics are applied, and it is covered with a dressing. Option 1 describes a wound secondary to argon laser surgery. Laser surgery is used for port-wine stains, telangiectases, and venous lakes. Option 3 describes Cryosurgery. Cryosurgery destroys the tissue by freezing agents that include liquid nitrogen. This procedure is used on many skin lesions. Option 4 describes the wound from fusiform excision. In this procedure, the full thickness of the epidermis and dermis along with a thin layer of subcutaneous tissue is removed. It is used for biopsies and complete removal of benign and malignant lesions.

**103.** A client has multiple oval bald patches on the scalp as well as on other hairy parts of the body. The nurse documents this as which of the following types of alopecia?

1. male pattern baldness
2. alopecia areata
3. alopecia totalis
4. alopecia universalis

(2) Alopecia areata is characterized by round or oval bald patches on the scalp and other hairy parts of the body. It is of unknown etiology and usually resolves without treatment. Male pattern baldness is characterized by hair loss that begins at the temples with a receding hairline and baldness at the crown. Alopecia totalis is the loss of all the hair on the scalp. It is irreversible. Alopecia universalis is characterized by total loss of hair over the entire body.

**104.** Which of the following results of a radical vulvectomy would have the greatest impact on the woman's body image?

1. recurrent cellulites
2. loss of ability to bear children
3. inability to have sexual intercourse
4. potential for skin breakdown with radiation therapy

(3) When a radical vulvectomy is performed, the woman loses her ability to have sexual intercourse. Many older women are still sexually active so this represents a great loss to them, and they will meet the defining characteristics for disturbed body image. Most women who have vulvar cancer are in their 60s and 70s and already have lost the ability to

bear children. It is true that women who have undergone vulvectomies have recurrent cellulites and the potential for skin breakdown. However, the perception of those effects will not have as negative an impact on body image as the loss of sexual function.

**105.** When a client has hepatitis, which of the following clinical manifestations would indicate to the nurse the client is at risk for developing a disturbed body image?

1. muscle or joint pain, change in color of stools, jaundice of skin and sclera
2. jaundice of skin and sclera, associated rashes and itching
3. fatigue, anorexia, nausea, and vomiting
4. abdominal contour, color of urine, changes in bowel elimination

(2) The symptoms of hepatitis most likely to contribute to the development of disturbed body image are jaundice of the skin and sclera, associated rashes and itching. When a client's appearance is negatively impacted, that leads to a change in how they and others view their body and ultimately leads to a disturbed body image. All of the options contain clinical manifestations of hepatitis but not all of the symptoms in each option have a visual component or would cause the client to have a negative perception of their body. Those symptoms with a visual component are the most likely symptoms to negatively impact body image.

**106.** A client with hyperthyroidism demonstrates goiter, amenorrhea, decreased fertility, decreased libido, weight loss, and hand and eye tremors. These clinical manifestations would substantiate a nursing diagnosis of:

1. risk for decreased cardiac output.
2. disturbed sensory perception: visual.
3. imbalanced nutrition: less than body requirements.
4. disturbed body image.

(4) All of the symptoms mentioned are clinical manifestations of hyperthyroidism. Collectively, they all can be major or minor defining characteristics of disturbed body image. Clinical findings for risk for decreased cardiac output in clients with hyperthyroidism include hypertension, tachycardia, dysrhythmias, and palpitations. Clinical manifestations of disturbed sensory perception: visual for clients with hyperthyroidism include blurred vision, photophobia, lacrimation, and exophthalmos. Clinical manifestations of imbalanced nutrition: less than body requirements in a client with hyperthyroidism include hunger, weight loss, nausea and vomiting, diarrhea, and fluid volume deficit.

**107.** Which of the following clinical manifestations of Graves' disease would make the client most at risk for developing a disturbed body image?

1. lacrimation
2. exophthalmos
3. photophobia
4. blurred vision

(2) Exophthalmos, also called proptosis, is the forward protrusion of the eyeball. This condition prevents the eyelids from closing and makes the sclera visible above the iris. Clients with exophthalmos have a characteristic unblinking stare. Because the eyelids cannot close, it also predisposes the client to corneal dryness, irritation, infection, and ulceration. Lacrimation, photophobia, and blurred vision are not as visible to the friends and family of the client, thereby not having as great an impact on body image.

**108.** When a client has acromegaly, the nurse would expect to identify all the following changes in appearance except:

1. increased length of the maxilla.
2. enlarged tongue.
3. thinned lips.
4. thickening of the nose.

(3) As a result of hypersecretion of growth hormone in a client with acromegaly, bone and connective tissue continue to grow. The long bones are not affected since the epiphyses have closed. However the forehead enlarges, the maxilla lengthens, the tongue enlarges, and the voice deepens. The cheekbones also enlarge, and soft-tissue structures such as the nose, lips, cheeks, and flesh above the eyebrows thicken.

**109.** When a client with lymphedema asks the nurse what their leg will be like as the disease progresses, the best response by the nurse would be:

1. "Your leg will begin to swell at the top and move downward."
2. "The swelling will be hard to feel, and you will experience some pain."
3. "Your skin will get darker in color and begin to get ulcers."
4. "As your disease progresses, the skin will become thick and rough and feel like wood."

(4) As the disease becomes chronic, the subcutaneous tissues become fibrotic causing thick, rough skin with a woody texture. This phenomenon is called brawny edema. Option 1 is wrong because the edema or swelling begins distally and moves up the extremity. Initially the edema is very soft and pitting. Generally, there is no pain experienced with lymphedema. Venous disorders are characterized by increased pigmentation and stasis dermatitis as suggested in option 3.

**110.** When a client who is scheduled for a radical neck dissection says to the nurse, "I'm really worried that I won't be able to communicate with anyone after the surgery," the best response by the nurse would be:

1. "Let's start planning now how to use flash cards or a magic slate for you to talk with us."
2. "We'll be sure to check with your spouse to see what you're trying to tell us."
3. "We'll just ask you yes or no questions so all you have to do is shake your head."
4. "I'm sure the doctor will refer you to a speech therapist who should be able to help you with this."

(1) Prior to the surgery the nurse should help the client practice different methods of communication that do not require speech, such as using flash cards or a magic slate. The spouse may have a general idea what is trying to be communicated, but the patient is expressing a desire to communicate on their own and may be afraid their spouse will not know what they want. Asking yes and no questions can be beneficial and is one of the tools used to communicate with these clients, but they should be encouraged to express their thoughts beyond yes and no. A speech referral can be made but that implies a time of waiting to learn to communicate. An immediate plan should be put into place and can later be augmented by a speech therapist. The client might not feel well enough to engage in therapy for a few days after the surgery and should have a means of communicating until therapy begins.

**111.** When a client has oral cancer, which of the following medical treatments should the nurse expect to have the greatest negative impact on body image?

1. radiation
2. chemotherapy
3. biopsy and staging
4. radical neck dissection

(4) A radical neck dissection is reserved for those clients with advanced carcinomas who require extensive surgery and is very disfiguring. During the radical neck dissection, lymph nodes and neck muscle are removed along with the tumor. In addition, a tracheostomy is performed that many times becomes permanent. Radiation, chemotherapy, biopsy, and staging all impact in a negative way the person's body image, but the physical appearance changes and communication difficulties as a result of the radical neck will have a much greater impact.

**112.** Which of these interventions demonstrates the nurse's acceptance of the client who as a result of psoriasis has a disturbed body image?

1. Promote social interaction through family involvement in care.
2. Touching the client during interactions.
3. Encourage the client to verbalize feelings about self-perception.
4. Demonstrate methods to reduce injury to the skin.



(2) The lesions of psoriasis often cause clients to isolate themselves. By touching the client during interventions, the nurse is able to demonstrate that the lesions are not contagious or offensive. Promoting social interaction through family involvement helps the client experience the family's acceptance but doesn't demonstrate the nurse's acceptance. Encouraging the client to verbalize feelings about self-perception is a nursing intervention for disturbed body image but does not convey that the nurse accepts the client. Demonstrating methods to reduce injury to the skin is a nursing intervention for those clients with psoriasis who have a nursing diagnosis of impaired skin integrity, not disturbed body image.

**113.** Which of the following types of fungal infections will most likely place the client at risk for developing a disturbed body image?

1. tinea pedis
2. tinea corporis
3. tinea versicolor
4. tinea capitis

(4) Body image is greatly impacted by appearance. Of the four types of fungal infections listed tinea capitis is the most visible to family and friends. Because of the location of the other fungal infections, family and friends may not even be aware the client has the infection. Tinea capitis is a fungal infection of the scalp. It is manifested by gray lesions, round bald spots, erythema, and crusting of the lesions and hair loss. Tinea pedis is a fungal infection of the soles of the feet, skin between the toes and/or the toenails. The lesions can become painful fissures with drainage and are accompanied by a foul odor and pruritus. Tinea corporis is a fungal infection of the body. Most commonly, the lesions are large circular patches with raised erythematous borders around vesicles, papules or pustules. Tinea versicolor is a fungal infection of the upper chest and back with occasional involvement of the arms. The lesions are yellow, pink, or brown. The involved areas do not have pigment and do not tan.

**114.** Which of the following endocrine and metabolic effects of end-stage renal disease are the most likely to negatively impact the client's body image?

1. insulin resistance
2. elevated blood triglycerides
3. menstrual irregularities
4. impotence

(4) Reproductive function is affected by end-stage renal disease. In males, reduced testosterone levels, low-sperm counts, and impotence will greatly affect how they perceive themselves and how their significant other will perceive them. Menstrual irregularities in the female will also affect body image but will not have as great a negative impact as lack of sexual function. If insulin resistance leads to insulin administration, body image could be impacted but still not to the degree as impotence. Elevated blood triglycerides is largely unnoticed in terms of body image. It would become a factor secondarily if it led to complications such as stroke.

**115.** When a client has uremia, which of the following neurologic effects most places the client at risk for disturbed body image?

1. impaired motor function
2. decreased deep tendon reflexes
3. gait disturbances
4. stocking-glove pattern paresthesias

(3) Gait disturbance is the most obvious and most debilitating of the neurologic effects of uremia listed. Options 1, 2, and 4 are neurologic manifestations of uremia and also cause disturbed body image. Impaired motor function may be visible to family and friends or may be experienced only by the client. The client is probably unaware of decreased deep tendon reflexes. The stocking-glove pattern of paresthesias and sensory loss will impact how the client functions but will not have as great an impact on independence and self-care as a gait disturbance that may preclude ambulation without assistance.

**116.** The nurse should include all of the following when teaching a client who has rheumatoid arthritis behaviors to enhance independence except:

1. purchase clothes that have elastic waist bands instead of zippers.
2. use tablespoons to feed self.
3. install grab bars in the bathroom.
4. wear shoes with Velcro closures.

(2) When teaching a client with rheumatoid arthritis eating behaviors that enhance independence, they should be instructed to use utensils that have oversized or special handles, not oversized capacity. Options 1, 3, and 4 are all appropriate self-care behaviors for clients with rheumatoid arthritis.

**117.** The teaching plan for a client who is having a vasectomy should include which of the following?

1. Back-up contraception should be used 2–3 months after the procedure.
2. Reversal procedures result in a pregnancy rate of 5–10 percent.
3. Remaining sperm in the vas deferens takes 6–36 ejaculations to clear.
4. Sperm count is checked at 2 months.

(3) There will still be some sperm present in the vas deferens after the vasectomy. It will take 6–36 ejaculations to clear the remaining sperm. On the average, that means for 4–6 weeks following the procedure there may still be enough sperm present to result in a pregnancy. For the 4–6 weeks following the procedure, the couple should use another method of birth control. During this time, 2–3 samples of semen should be brought in for a sperm count. To be sure a spontaneous reanastomosis has not occurred, the man should have a sperm count again at 6 and 12 months following the procedure. Through microsurgery vasectomies may be able to be reversed. The shorter the time from the procedure to the reversal, the greater the chance of a pregnancy occurring. The anticipated pregnancy rate following a vasectomy reversal is 30–76 percent.

**118.** When a client asks the nurse about which female sterilization technique is the easiest to reverse, the best response by the nurse is:

1. crushed.
2. ligated.
3. electrocoagulated.
4. banded.

(4) The banded and plugged techniques are newer techniques for female sterilization of the fallopian tubes and are considered reversible. Reversal success depends on the type of procedure done. With the assistance of microsurgical techniques, it is possible to have a subsequent pregnancy rate of 44–88 percent. When the fallopian tubes are crushed, there is more destruction of the tube making a reversal more problematic. When they are ligated, there can be damage to the tube as well, but not as much as when crushed or electrocoagulated. When the tubes are electrocoagulated, they are essentially cauterized/burned to cause the separation making reanastomosis very difficult.

**119.** When obtaining a health history from a male client who is concerned that he is infertile, which information should a nurse recognize as most critical?

1. normal semen analysis
2. obesity
3. ejaculate deposited at the cervix
4. normal genital tract secretions

(2) Obesity can prevent adequate penetration, resulting in ejaculation and sperm deposit well away from the cervix. Being able to ejaculate at the cervix increases the probability of pregnancy. Normal semen analysis is important but does not give any clues other than exclusion as to what may be causing the inability to conceive. If the male is able to ejaculate at the cervix, that is the expected outcome and promotes conception. Normal genital tract secretions means absence of disease, tumors, and autoimmunity to semen, all of which could cause infertility.

**120.** Which of these factors, if identified in the history of a female client who has been trying to conceive for more than a year is most likely related to the development of infertility?

1. lack of artificial lubricants during intercourse
2. frequency of intercourse two times a week
3. pelvic inflammatory disease
4. female superior position during intercourse

(3) Pelvic inflammatory disease can damage the fallopian tubes and prevent the sperm from reaching the ovum, thereby preventing pregnancy. The use of artificial lubricants can alter the pH of the cervical mucus, making it inhospitable to sperm. So the lack of use of artificial lubricants would not contribute to infertility. When trying to conceive, the couple should have intercourse three times a week no less than 48 hours apart. Although option 2 suggests the couple only has intercourse twice a week, it is still not the most likely related cause of infertility. Should they increase the number of times they have intercourse, their chances of conceiving would increase. When ejaculation occurs during the female superior position there will be leakage or loss of sperm from the vagina due to the gravitational pull. To assist with conception, the couple should use the male superior position.

**121.** The nurse should include all of the following in a teaching plan to promote fertility except:

1. avoid douching and use of artificial lubricants.
2. elevate the woman's hips with a pillow after intercourse for 1 hour.
3. utilize the female superior position during intercourse.
4. maintain adequate nutrition and reduce stress.

(3) To promote the retention of sperm, the male superior position should be utilized during intercourse, and the female should remain in the recumbent position for 1 hour after intercourse. This maximizes the number of sperm that reach the cervix. Douching and artificial lubricants may alter the pH of the vagina and/or wash the sperm out of the vagina. By elevating the woman's hips for an hour after intercourse, it helps prevent leakage of the sperm from the vagina. Maintaining adequate nutrition and reducing stress will increase the sperm production, increasing the chances of pregnancy.

**122.** When a client asks the nurse whether it is true that the majority of the fertility problems belong to the female partner, the best response by the nurse is?

1. "The male is responsible for 35 percent of infertility problems."
2. "The female is responsible for 65 percent of infertility difficulties."
3. "About 25 percent of the time, we do not find out why a couple is infertile."
4. "Both partners are responsible for the infertility 5 percent of the time."

(1) There is a problem with the male reproductive system in 35 percent of couples experiencing infertility. Infertility is caused by a female factor 50 percent of the time. About 15 percent of the time, the cause is either unidentified or a problem with both partners. There are another 35 percent of the couples who experience multiple causes. Fertility care and counseling can help 65 percent of couples experiencing infertility to conceive.

**123.** Which of these factors, if identified in the history of a client who is infertile, is most likely related to an abnormal semen analysis?

1. varicocele
2. smoking
3. impotence
4. infections

(2) Semen analysis looks at the sperm count, the motility of the sperm, and morphology of the sperm. Smoking is the only option listed that affects those characteristics. A varicocele may impact fertility because of the obstruction of the genital tract. Impotence will not impact the sperm analysis but will prevent sperm from being released during intercourse, thus preventing pregnancy. Infections can alter the normal genital tract secretions as well as cause structural damage, preventing pregnancy, but not altering the sperm analysis.

**124.** When a client, who is 25 years of age, asks the nurse when she should seek fertility counseling, the best response by the nurse is:

1. "When you have been unable to conceive after one year of unprotected intercourse."
2. "If you have not been able to conceive after 6–9 months of unprotected intercourse."
3. "The average time it takes someone your age to conceive is 5 ½ months, so if you haven't conceived by then, we can refer you."
4. "We can give you some guidance now on how to increase your chances of conceiving and then refer you if it doesn't happen within a year."

(4) The guidelines for a fertility work-up are to refer after the couple has not conceived after one year of unprotected intercourse. So, option 1 is technically correct, but it doesn't consider the immediate need for the couple to have some counseling. Option 4 is the best answer because it gives the couple guidance now and the referral at the appropriate time. If the woman is over the age of 35, an earlier referral, at 6–9 months of unprotected intercourse, is appropriate. It is true the average time it takes a 25-year-old to conceive is 5.3 months, but that does not address the concern the client is expressing. Option 4 is still the most caring and correct answer. Couples conceive within the first month of unprotected intercourse 20 percent of the time.

**125.** When a couple experiencing infertility presents for a fertility work-up, which of the following procedures should the nurse prepare the couple to have first?

1. hysterosalpingography
2. semen analysis
3. endometrial biopsy
4. transvaginal ultrasound

(2) Because semen analysis is the least invasive of the tests listed and because in 35 percent of the cases the infertility is related to a male factor, semen analysis is one of the first diagnostic tests done. Hysterosalpingography fills the uterus and fallopian tubes with a radiopaque substance that can be seen on x-ray. It demonstrates tubal patency or any distortion of the uterine cavity. Endometrial biopsy provides information about the effects of progesterone after ovulation and the endometrial receptivity. Transvaginal ultrasound is mostly used in the treatment of infertility. For diagnosis it allows the endocrinologist to evaluate the developing follicle, assess oocyte maturity and diagnose luteal phase defects. All the tests listed in options 1, 3, and 4 are more invasive, require greater expertise to evaluate and treat, and are more costly. If the semen analysis is normal, the couple can expect to progress through these tests as well.

**126.** Which of the following tests for ovarian function should the nurse prepare the client for on the twenty-first day of her cycle?

1. FSH (follicle-stimulating hormone)
2. TSH (thyroid-stimulating hormone)
3. LH (leutinizing hormone)
4. progesterone assay

(3) Progesterone levels are the best evidence of ovulation and the functioning of the corpus luteum. On the twenty-first day of the cycle, a level of 10 ng/mL or higher indicates an adequate luteal phase. Follicle-stimulating hormone is measured on the third day of the cycle and is the single most valuable test of ovarian reserve and function. Thyroid-stimulating hormone would be performed if indicated. Leutinizing hormone is responsible for the final maturation of the follicle. There is a surge in LH at midcycle. Many times the woman must have daily LH levels drawn to detect the surge.

**127.** Which of the following laboratory values of semen analysis would indicate a possible cause of the couple's infertility?

1. volume of semen greater than 2 mL
2. less than 5 million round cells/mL
3. total sperm count of 2 million/mL
4. semen pH of 7 to 8

(3) A sperm count less than 20 million is considered part of the diagnostic criteria for infertile semen. The laboratory values listed in options 1, 2, and 4 are normal values of semen analysis.

**128.** All of the following laboratory values would indicate to the nurse that the client has infertile semen except:

1. fewer than 20 million sperm/mL.
2. less than 50 percent motility at 6 hours.
3. less than 30 percent normal sperm forms.
4. greater than 1 million white cells/mL.

(4) A normal semen analysis contains less than 1 million white cells/mL. When the values listed in options 1, 2, and 3 are met, the man is determined to have infertile semen. Normal semen analysis includes greater than 20 million sperm/mL, 50 percent or greater motility at 6 hours, and 30 percent or greater normal forms.

**129.** Which of these factors, if identified in the history of a client, would indicate the semen specimen is not acceptable for analysis?

1. intercourse or ejaculation within 1–2 days prior to collecting specimen
2. use of regular or latex condom to collect the specimen
3. presence of a fever-producing illness
4. specimen collected by masturbation versus intercourse

(4) Semen specimens are usually collected by masturbation to avoid contamination or loss of semen. However, if the man is having trouble collecting the specimen via masturbation, a medical-grade condom may be used during intercourse. Intercourse or ejaculation should be avoided for 2–3 days prior to collecting the specimen. Regular or latex condoms should be avoided because they contain spermicidal agents and sperm can be lost in the condom. Fever can kill sperm so if a man has a fever-producing illness, analysis of the semen should be delayed by 2½ months.

**130.** Which is the primary responsibility of the nurse when preparing a client for the Huhner test (postcoital test)?

1. Obtain intravenous access and start fluids at a KVO rate.
2. Instruct the couple to have intercourse up to 12 hours prior to the test.
3. Administer a prostaglandin synthesis inhibitor 30 minutes before the procedure.
4. Keep client in a supine position following the test to relieve discomfort.

(2) The postcoital test or Huhner test is performed 1–2 days prior to anticipated ovulation and evaluates the cervical mucus, sperm motility sperm-mucus interaction, and the sperm's ability to move through the cervical mucus barrier. The couple can have intercourse up to 12 hours prior to the test. If the results are abnormal, the test can be repeated 2–3 hours after intercourse. Intravenous access is not necessary for the Huhner test, nor is it necessary for many other fertility tests or procedures. When a woman is having a hysterosalpinogography, a prostaglandin synthesis inhibitor such as ibuprofen is administered 30 minutes before the procedure to minimize discomfort. This is not required for the Huhner test. Following a laparoscopy and the injection of carbon dioxide gas into the abdominal cavity, the client's discomfort can be reduced if encouraged to remain supine. The Huhner test is not a surgical procedure, and carbon dioxide gas is not injected.

**131.** A client is receiving clomiphene citrate (Clomid). A nurse should plan to teach the client to observe for side effects which include all of following except:

1. visual disturbance.
2. urinary frequency.
3. hair loss.
4. palpitations.

(4) There are no cardiovascular side effects listed for Clomid. Visual disturbances such as blurred vision, spots, or flashes can occur and may necessitate discontinuing the drug. Urinary frequency and polyuria are urinary side effects and resolve when the drug is discontinued. Hair dryness and hair loss are also side effects of Clomid.

**132.** Which of the following medications, if ordered for a client experiencing infertility, would the nurse administer when endometriosis is the cause of the infertility?

1. Clomiphene citrate (Clomid)
2. Urofollitropin (Fertinex)
3. Danazol (Danocrine)
4. Bromocriptine (Parlodel)

(3) Danazol (Danocrine) is given to suppress ovulation and menstruation and to induce atrophy of the ectopic endometrial tissue characteristic of endometriosis. Clomiphene citrate (Clomid) is administered if there is an ovulation defect and induces ovulation in 80 percent of the women who take it. Urofollitropin (Fertinex) is used as a first-line therapy in anovulatory infertile women who have low to normal levels of gonadotropins and as a second-line therapy in women who fail to ovulate while taking clomiphene citrate. Bromocriptine (Parlodel) is used when anovulation is accompanied by hyperprolactinemia.

**133.** When a client has been given human chorionic gonadotropin to stimulate ovulation, within how many hours should the nurse instruct them to have intercourse?

1. 6–12 hours
2. 12–24 hours
3. 24–36 hours
4. 36–48 hours

(3) Couples should be instructed to have intercourse within 24–36 hours of the woman being injected with human chorionic gonadotropin. This medication is administered when follicle maturation has occurred and will stimulate ovulation. They should also have intercourse for the next two days. Having intercourse 6–12 hours after or 12–24 hours after is too soon for ovulation to have occurred. Having intercourse 36–48 hours is too late to capture the release time but does fall within the “next two days” portion of the instructions.

**134.** When a client has inadequate volumes of sperm, decreased motility, and anatomic defects accompanied by inadequate deposition or penetration of semen, or retrograde ejaculation, which of the following fertility procedures would the nurse prepare the client for first?

1. in vitro fertilization
2. therapeutic donor insemination (TDI)
3. therapeutic husband insemination (THI)
4. gonadotropin therapy

(3) The term therapeutic insemination has replaced the old terminology of artificial insemination and involves depositing semen at the cervix or in the uterus with the assistance of mechanical means. The insemination procedure of choice for the client described is therapeutic husband insemination (THI). Therapeutic donor insemination (TDI) is used for those couples in which there is azoospermia, autosomal dominant disorders, and inherited male sex-linked disorders.

In vitro fertilization would not be the first fertility procedure performed if the fertility problem was consistent with the description provided. It is reserved for infertility related to tubal factors, mucus abnormalities, immunologic infertility, and cervical factors. Gonadotropin therapy is used for clients when ovulation needs to be stimulated.

**135.** Which of the following strategies for screening and processing procedures for therapeutic donor insemination should the nurse confirm in the record before insemination is begun?

1. completed genetic screening on donor
2. completed infectious disease screening on donor and recipient
3. informed consent signed by the donor
4. record of 4-month quarantine on sperm

(2) A complete infectious disease screening must be performed on the donor at the time of the donation and again before the sperm can be released for use. Infectious disease screening must also be performed on the recipient. Genetic screening is mandatory not only for the donor but also the recipient. Informed consent must be signed by all parties involved, not just the donor. Donated sperm must be frozen and quarantined for six months prior to actual insemination to prevent transmitting infectious diseases. Options 1 and 3 are partially correct as the recipient is not included in the answer. Option 2 is most correct because it includes both the donor and recipient.

**136.** When a woman has undergone in vitro fertilization, which of the following measures, if included in the plan of care, would be most effective to assist the woman in achieving pregnancy?

1. Encourage minimal activity for the first 6–12 hours.
2. Take progesterone supplementation as prescribed.
3. Administer human chorionic gonadotropin intramuscularly.
4. Monitor oocyte maturity with hormonal assays and ultrasound.

(2) Progesterone supplementation will stimulate a positive uterine environment to maintain pregnancy. Option 1 is wrong because it doesn't encourage minimal activity up to the first 24 hours. Human chorionic gonadotropin is administered prior to the in vitro procedure to induce ovulation. Hormonal assays and ultrasound are used prior to the procedure to monitor follicle and oocyte maturity to know when to administer the human chorionic gonadotropin.

**137.** Which of the following differences between in vitro fertilization (IVF) and gamete intrafallopian transfer (GIFT) is most likely to be the reason those clients with religious concerns about fertility procedures would agree to GIFT over IVF?

1. In GIFT fertilization takes place in the fallopian tube.
2. GIFT is less invasive and costly than IVF.
3. The embryo in GIFT is transferred much earlier than IVF.
4. GIFT does not allow fertilization to be documented.

(1) In GIFT the oocytes are placed in a catheter with washed, motile sperm and placed into the fimbriated end of the fallopian tube. Fertilization takes place in the fallopian tube. Because fertilization does not take place outside the woman's body, the GIFT procedure is more acceptable to some religions. IVF is less expensive and less invasive than GIFT, but cost and invasiveness are not the usual concerns some religions have with fertility procedures. There is no transfer of embryos in GIFT as fertilization takes place in the fallopian tube after the sperm and oocytes are placed there. A procedure called ZIFT or zygote intrafallopian transfer does place the embryo in the fallopian tube at an earlier stage of development than IVF. It is true that GIFT does not allow fertilization to be documented and IVF does, but again, where fertilization takes place is the issue for some religions.

**138.** When a client with an autosomal dominant inherited disorder asks the nurse what the chances are of having an affected baby, the best response by the nurse is?

1. "Even if your baby inherits the disorder, it can be mild."
2. "Statistically 50 percent of your children will be affected."
3. "If your baby is a boy, it has a 50-50 chance of being affected."
4. "It can be worth the risk if you want a child badly enough."

(2) In autosomal dominant disorders one parent is affected and statistically 50 percent of the children will be affected regardless of the sex. Option 2 is also the most honest, direct answer to the client's question. Option 1 is true in that autosomal dominant disorders can vary widely in the degree to which they affect the child, but this response does not answer the client's question; it side steps it. Option 3 alludes to X-linked, not autosomal dominant disorders. In X-linked disorders, statistically 50 percent of the males are affected and 50 percent of the females are carriers. Option 4 is judgmental, condescending, and does not answer the client's question.

**139.** The teaching plan for a client with an autosomal recessive disorder who is considering becoming pregnant should include which of the following?

1. Each pregnancy has a 25 percent chance of resulting in an affected child.
2. Male children will have a greater chance of being affected.
3. If both partners are clinically normal, a child will not be affected.
4. If both partners are carriers, there is a 50 percent chance the gene will be passed on to any offspring.

(1) In autosomal recessive disorders each pregnancy has a 25 percent chance of resulting in an affected child regardless of the sex. Males and females are affected equally. An affected child may have clinically normal parents, but both parents will be carriers of the gene. If both partners are carriers of the gene, there is a 25 percent chance the gene will be passed on to any offspring.

**140.** Which of these statements, if made by a male client with an X-linked recessive disorder, indicates correct understanding of transmission?

1. "All of my sons will be affected."
2. "My father had this disease and passed it on to me."
3. "I have a 50 percent chance of passing the gene to a daughter."
4. "If my daughter is a carrier, there is a 50 percent chance each of her sons will be affected."

(4) The carrier mother of an X-linked recessive disorder has a 50 percent chance that each of her sons will be affected with the disorder. There is also a 50 percent chance that she will pass the normal gene to each of her sons and a 50 percent chance that each of her daughters will become carriers. There is no male-to-male transmission of X-linked recessive disorders. If an affected male has children, none of his sons will be affected, but all of his daughters will become carriers. The client's father could not have passed the disease to him as there is no male-to-male transmission.

**141.** When a client who is over the age of 35 becomes pregnant and asks the nurse about chromosomal abnormalities, the best response by the nurse is?

1. "We will do some tests early in your pregnancy to see whether there are any abnormalities."
2. "There is only a risk for chromosomal abnormalities if you've already had an affected child."
3. "We can detect many metabolic disorders in utero and help you make any decisions at that time."
4. "For women 35 or older, the risk of having a child with a chromosomal abnormality is 1 in 200."

(4) Option 4 is not only true but is the most direct and caring option offered. For this age group, the risk of having a child with trisomy 21 is 1 in 365. At 45 years of age, the risk of chromosomal abnormalities increases to 1 in 20. Option 1 is true. Genetic amniocentesis can be performed at 14–16 weeks of gestation, and a client 35 years of age or older meets the criteria for that procedure. However, option 1 does not directly answer the immediate concern expressed by



the client. Option 2 only partially addresses the concern. It is true that if the client has already had a child with a chromosomal abnormality, there is an increased risk with subsequent pregnancies, but this option does not adequately or directly address the generic risks. Many metabolic disorders can be detected in utero, but metabolic disorders are not necessarily chromosomal disorders. The client asked about chromosomal disorders.

**142.** Which of these factors, if identified in the history of a client who is pregnant, is most likely an indication for prenatal amniocentesis or chorionic villus sampling?

1. The woman will be 30 years of age or older at the time of birth.
2. One partner is a carrier for a metabolic disorder.
3. Maternal serum alpha fetoprotein level of 90 ng/mL.
4. Maternal diabetes.

(4) Maternal diabetes places the fetus at risk for teratogenic effects. Making prenatal diagnosis available to the client then allows the couple to decide whether or not to continue with the pregnancy should a defect be present. Prenatal diagnostic procedures are indicated if the woman will be 35 or older at the time of the birth. Both partners must be carriers of a metabolic disorder for the fetus to be affected, so just one partner being a carrier is not an indication for prenatal testing. The level of maternal serum alpha fetoprotein listed in option 3 is normal. Low or high levels would be an indication for prenatal diagnosis.

**143.** When a couple presents for preconception genetic counseling, which ethnic background should a nurse recognize as an indication to screen for alpha-thalassemia?

1. Ashkenzic Jewish
2. Greek
3. Cambodian
4. Caribbean Hispanic

(3) Couples whose ethnicity is southeast asian (Vietnamese, Laotian, or Cambodian) or Filipino are at increased risk for having a child with alpha-thalassemia. The screening test for this is a mean corpuscular volume less than 80 percent followed by hemoglobin electrophoresis. If these tests are positive, definitive testing via chorionic villus sampling or amniocentesis can be done. Couples with Ashkenzic Jewish ethnicity should be screened for Tay-Sachs disease. Greek couples are at risk of having a child with beta-thalassemia. Caribbean Hispanic couples are at risk for having a child with sickle-cell anemia.

**144.** Which of the following screening tests would indicate to the nurse that further definitive prenatal diagnosis is indicated to determine whether the fetus has Tay-Sachs disease?

1. elevated maternal serum alpha-fetoprotein
2. confirmatory hemoglobin electrophoresis
3. mean corpuscular volume less than 80 percent
4. decreased serum hexosaminidase-A

(4) A decreased serum hexosaminidase-A is a positive screening test for Tay-Sachs and an indication for more definitive prenatal diagnostic testing such as chorionic villus sampling, amniocentesis, or hexosaminidase-A assay. An elevated maternal serum alpha-fetoprotein is a positive screening test for open neural tube defects, anencephaly, imperforate anus, and gastroschisis. This is an indication for further prenatal diagnostic testing such as amniocentesis and ultrasound. Confirmatory hemoglobin electrophoresis and mean corpuscular volumes of less than 80 percent are both screening tests for sickle-cell anemia, beta-thalassemia, and alpha-thalassemia. These screening tests are followed by definitive prenatal testing of chorionic villus sampling or amniocentesis or direct molecular studies.

**145.** Which of these factors, if identified in the history of an adolescent, is most likely related to the development of an unplanned pregnancy?

1. unable to make conscious decisions about their sexual and contraceptive behavior
2. known access to reliable and affordable contraceptives
3. belief that she can become pregnant and that contraceptives will prevent pregnancy
4. is known as the “bad one” in the family, experiencing parental neglect and hostility

(1) Research has shown that most adolescent females delay seeking contraceptives and become pregnant either because they are unwilling or unable to make conscious decisions about their sexual and contraceptive behavior or because they do not mind becoming pregnant. Occasionally, emotionally deprived adolescents may become pregnant as a way to allow parents or themselves to escape the parental responsibility. Many will have filled the scapegoat role in the family as the “bad one.” Having access to reliable and affordable contraceptives, believing that she can become pregnant, and believing that contraceptives will prevent pregnancy are all necessary for adolescent females to routinely utilize contraceptives.

**146.** When an infant is diagnosed with congenital adrenal hyperplasia, which of the following measures would assist the family to cope while sexual identity is being determined?

1. Rear the infant as the desired sex until the determination is made.
2. Refer to the infant as a “he” until determination is made.
3. Inform family members the sex of the infant by phenotype.
4. Dress the infant in unisex clothing until sexual identity is determined.

(4) Dressing the infant in unisex clothing prevents family, friends, and the casual onlooker from exclaiming over a boy or girl as typified by clothing. This allows the parents to experience their child without being reminded of a specific sex assignment by looking at the child’s clothing. Parents and healthcare providers should avoid assigning sexual identity until it has been genetically determined and a decision has been made as to which sex the child will be raised as. Parents should be encouraged to teach both sex roles to children until the decision has been made. The infant should be referred to as the “baby” or “child” rather than as “he” or “she” to avoid premature sexual assignment. It is very tempting for parents to refer to the infant as the sex they look like, or the phenotype, particularly if that was the desired sex of their child. However, premature assignment of the infant’s sex will make future decisions more difficult and increase the challenges the family will face.

**147.** The teaching plan for an infant who has congenital adrenal hyperplasia and has just been assigned the genetically determined sex should include all of these instructions except?

1. Choose an appropriate name.
2. Identify the infant as male or female.
3. Show parents before and after pictures of surgical reconstruction.
4. Medication will be required until the child reaches puberty.

(4) The medical regimen/medications for congenital adrenal hyperplasia are a lifelong commitment that does not end at puberty. The child and parents will need to know how to inject hydrocortisone as well as other treatment modalities. Options 1, 2, and 3 are all important instructions for the teaching plan of this child. Giving a name to their child is an important parental role. After genetic sex has been determined, the parents should immediately choose an appropriate name. Until the genetic sex determination is made, the parents can assign a unisex name to the child that can be expanded to a specific sex. For example, they can call the child “Chris” and after the sex is determined, expand the name to Christopher or Christina. When the genetic sex is determined, the parents should stop referring to the child as “baby” or “child” and begin identifying the infant as “he” or “she.” References to ambiguous genitalia should stop, and the child should be referred to only by their genetic determined sex. Many times, there will still be an abnormal appearance to the genitalia, and surgical reconstruction is required. Parents will have many questions about how their child will look. Showing them before and after pictures of surgical reconstruction can be very beneficial to their understanding.

**148.** When the parent of a preschooler says to the nurse, “My child keeps asking me where babies come from, and I don’t know what to say,” the best response by the nurse would be:

1. “Tell your child he is too young to know about such things.”
2. “Ask your child specifically what he wants to know.”
3. “You can just change the subject until you feel he’s really ready to know.”
4. “Only tell him what you think he can understand.”

(2) There are two basic guidelines for answering small children’s questions about sexual issues. One is to find out what it is they really want to know, and the second is to be honest. Many times parents find out after elaborate explanations that the child only wanted to know what state they were born in rather than all the biological details of how a baby is born. When children are old enough to ask the questions, they are old enough for answers. By ignoring or delaying the discussion, as in options 1 and 3, the small child will proceed to make up their own explanation. Because preschoolers are still magical thinkers, any fantasy or terrifying thought they would have about the subject becomes true to them. Delaying or ignoring also conveys to the child the topic isn’t acceptable. Sexual behavior should be treated as a normal part of life, growth, and development. Many parents worry about whether or not they tell their children “too much” information. Knowledge really isn’t harmful, and most experts recommend telling children a bit more than you think they’ll understand. The idea isn’t that they understand everything but that they know they can ask their parent for the information they want.

**149.** Which of the following findings in a newborn would indicate to the nurse normal effects of maternal sex hormones?

1. enlarged clitoris
2. hypertrophied labia
3. engorged breasts
4. pseudomenstruation

(1) An enlarged clitoris is not normal and may be a clinical manifestation of congenital adrenal hyperplasia. This finding should be reported immediately to the physician. In many newborns, the maternal sex hormones will cause hypertrophied labia and engorged breasts. The breasts may even secrete milk, commonly called witch’s milk, during the first few days of life continuing as long as 2 months of age. Female newborns may have pseudomenstruation caused by a sudden drop in progesterone and estrogen. It is more often seen as a milky secretion rather than actual blood.

**150.** When a parent reports their child has been engaging in playing “doctor,” the nurse should recognize this behavior as indicative of:

1. normal curiosity and harmless sex play.
2. signs of sexual abuse.
3. sexual urges associated with love.
4. clinical manifestations of sexual deviancy.

(1) Many children experience some form of sex play. It reflects normal curiosity and is harmless. By 2–3 years of age, a child can note the anatomical differences between boys and girls and have a curiosity about it. A child who exhibits more knowledge about sexual practices, engages in inappropriate sexual behaviors, or is inappropriately flirtatious may have experienced sexual abuse and requires further assessment by the nurse. Normal curiosity and harmless sex play are not indications of abuse, nor are they associated with love or sexual urges. Normal curiosity and engaging in playing “doctor” are not clinical manifestations of sexual deviancy.

**151.** An adolescent girl is experiencing the appearance of pubic hair. A nurse should document this as:

1. thelarche.
2. adrenarche.
3. leukorrhea.
4. menarche.

(2) Adrenarche is the appearance of pubic hair and usually follows the appearance of breast development by 2–6 months. Thelarche, the development of a small bud of breast tissue, is the earliest and most easily visible change of puberty. Leukorrhea is the term applied to the increase in normal vaginal discharge. This is normal and indicates impending menstruation. Menarche, the onset of the first menstrual period, occurs in late puberty. Ovulation and regular menstrual periods usually begin 6–14 months after menarche.

**152.** A male pubescent client experiences gynecomastia. A nurse should recognize this finding as an occurrence of:

1. early puberty.
2. midpuberty.
3. late puberty.
4. abnormal.

(2) Gynecomastia is breast enlargement and tenderness in males. Up to  $\frac{1}{3}$  of boys experience this in midpuberty. It is usually temporary and disappears within two years. Clinical manifestations of early puberty in males include testicular enlargement, thinning and reddening with increased looseness of the scrotum, appearance of pubic hair, and penile enlargement. Late puberty is characterized by a definite increase in length and width of the penis, continued testicular enlargement, and the first ejaculation. Additional signs of late puberty include axillary and facial hair as well as voice changes.

**153.** A 14-year-old male has not experienced enlargement of the testes or scrotum. A nurse should recognize these signs as indicative of:

1. precocious puberty.
2. normal growth and development.
3. delayed puberty.
4. Tanner Stage II.

(3) Enlargement of the testes or scrotum normally begins as early as 10 years of age and continues through age 17 years. When this does not happen by age 13½–14 years the male is considered to have delayed puberty. The other criteria for delayed puberty occurs when the testes or scrotum fail to complete growth within four years of initial enlargement. Precocious puberty is the development of secondary sex characteristics before the age of 9 in boys. The development described in the question is not normal growth and development. Tanner Stage II is assigned when the testicles and scrotum begin to enlarge.

**154.** Four years ago, a 16-year-old African American girl began breast development, but has not yet had menarche. These findings would indicate to the nurse which of the following?

1. Tanner Stage IV
2. precocious puberty
3. normal growth and development
4. delayed puberty

(4) Delayed puberty in the female is characterized by lack of breast development by age 13 or failure to experience menarche within four years of the onset of breast development. The adolescent described in the question achieved breast development by age 13 but has failed to experience menarche within four years. Tanner Stage IV is characterized by near adult maturation of the breast. The difference between adult, Tanner Stage V, and this adolescent is that in Tanner Stage IV, the areola appears to set on top of the breast tissue versus having a single contour of the breast and areola. This adolescent is not experiencing normal growth and development. Precocious puberty in females occurs when the secondary sex characteristics develop before the age of 7 years in Caucasian girls and before the age of 6 years in African American girls.

**155.** The parents of a Down syndrome adolescent express concern related to the development of secondary sex characteristics. Which of the following should be included in teaching the parents about sexual development in Down syndrome?

1. Females tend to have little if any breast development.
2. Menstruation, if it occurs at all, will be later than normal.
3. Postpubertal women may be fertile.
4. Males will have normal secondary sex characteristics.

(3) Postpubertal women with Down syndrome may be fertile. Some have had children, but the majority of their children had congenital anomalies. Females will have mild to moderate breast development. Menstruation usually occurs at the average age. Males with Down syndrome are sterile.

**156.** When a child has been diagnosed with central precocious puberty, which of the following clinical manifestations would the nurse expect to identify?

1. appearance of all secondary sex characteristics at the same time
2. production of mature sperm or ovum
3. isolated premature thelarche
4. isolated premature menarche

(2) In central precocious puberty, gonadotropin-releasing hormone is activated early resulting in early maturation and development of the gonads with secretion of the sex hormones, development of secondary sex characteristics, and sometimes production of mature sperm or ovum. The secondary sex characteristics will not appear all at once but in the same order as if normal growth and development. Some children experience isolated manifestations of puberty such as thelarche (breast development), adrenarche (development of pubic hair), and menarche (onset of menses). These signs occur in isolation and are a variation of normal.

**157.** When teaching parents of a child who has precocious puberty how to cope with early sexual development, the nurse should include which of the following instructions?

1. Dress the child according to chronologic age, not sexual development.
2. Tell friends and family the child may begin to make sexual advances.
3. Consider placing the child on birth control pills to prevent pregnancy.
4. The most difficult years will be in adolescence and a referral should be made to the school counselor.

(1) The child should be dressed in clothing that is representative of the chronologic age, not sexual development. It can be confusing for some parents who begin dressing their child in older-looking clothes to accommodate increased breast size, and so on, but this places abnormal societal expectations on the child who is then looked on as older than they are. It may also prompt unwanted sexual advances toward the child. Children with precocious puberty continue to have a mental age consistent with their chronologic age and do not begin making sexual advances. They are more in danger of being taken advantage of sexually because of their mature physical appearance versus their mental age. Some children with precocious puberty are fertile and are at risk for becoming pregnant. Should contraceptives become a part of the care, birth control pills are contraindicated. The estrogen component of oral contraceptives will cause premature closure of the epiphyses with a result of short stature. The most difficult years for the child will be school-age years. When they become adolescents, they will look similar to their peers once again, and there are no longer any physical differences present.

**158.** When taking a sexual history from an adolescent, which of the following questions should the nurse ask first?

1. "Are you having sex with anyone?"
2. "How old were you the first time you had sex?"
3. "Are any of your friends having sex?"
4. "Do you use a condom when you have sex?"

(3) A nonthreatening way to explore an adolescent's sexual behavior is to begin the conversation asking about their peers. Adolescents tend to behave in similar ways as their friends. If their friends are having sex the next question is, "Have you ever considered having sex?" Option 1 may be a question that is asked at some point during the interview but is pretty threatening to the adolescent if the nurse begins there. If the adolescent admits to having sex, asking how old they were the first time they had sex is appropriate. To assume the adolescent has been sexually active can be offensive to them and cause them to distrust the nurse. If they admit to having sex, it is appropriate for the nurse to ask about condom use. If they deny having sex or considering having sex, the nurse can support their efforts of abstinence and make a contract with them that brings them back to discuss sexual issues should they decide to begin sexual intercourse.

**159.** When teaching adolescents about unique characteristics that place them at increased risk for sexually transmitted infections (STDs), the nurse should include all of the following except:

1. The columnar epithelium on the exocervix of the adolescent female is immature and favors attachment of organisms such as *Chlamydia trachomatis* and Human Papillomavirus (HPV).
2. The adolescent female's unchallenged immune system lacks the ability to mount an immune response at the cervical level when exposed repeatedly to infectious agents.
3. Adolescents are more prone to have anovulatory cycles in which estrogen predominates. The thin, clear, watery cervical discharge for anovulatory facilitates pathogens up the reproductive tract.
4. Adolescents lack the knowledge that many STIs can be asymptomatic or do not recognize the symptoms when they occur. This delays treatment and increases the incidence of complicated STIs.

(4) Option 4 is a true statement, but the question asks about the unique characteristics that put adolescents at increased risk for STIs. In this option, the adolescent has already acquired the STI and either does not have symptoms or does not recognize them. Options 1, 2, and 3 are all true and are unique characteristics that increase the risk of adolescents acquiring STIs.

**160.** When a client states that sexual activity is a natural extension of intimate relationships, which of the following basic values toward sexuality should the nurse recognize the client possesses?

1. absolutist or procreational position
2. hedonistic or recreational
3. relativistic or situational
4. relational or person-centered

(4) The relational or person-centered position views sexual activity as a natural extension of intimate relationships. The absolutist or procreational position states that sexuality exists for the purpose of reproduction. The hedonistic or recreational sex view has pleasure and pursuit as its central value and is interested in ultimate fulfillment of sexual potentials. The relativistic or situational position is based on research and has become the basis for the new morality, which says that acts should be judged on the basis of their effects.

**161.** When teaching young adults accurate information about sexuality, the nurse could include which of the following:

1. Female orgasm is initiated by clitoral stimulation.
2. Sex is the prevailing instinct in humans.
3. Erotic dreams culminating in orgasms occur in 25 percent of all men at any age.
4. Men have a stronger sex desire than women.

(1) It is true that female orgasm is normally initiated by clitoral stimulation, but the orgasm is a total body response. Many women need clitoral stimulation as well as intercourse to achieve orgasm. Sex is not the prevailing instinct in humans and physical or mental disease does not occur because sexual needs have gone unmet. Erotic dreams culminating in orgasms occur in 85 percent of men at any age. Women commonly experience erotic dreams that culminate in orgasm as well, and this increases as women age. Women have as strong a sex desire as men, sometimes stronger.

**162.** The teaching plan for a client who has premenstrual syndrome should include all of the following instructions except:

1. consume less caffeine in beverages.
2. limit snacks containing complex carbohydrates.
3. limit fat intake.
4. exercise at least four times a week.

(2) Snacks should include complex carbohydrates such as fresh fruits, vegetable sticks, and whole wheat crackers. These provide energy without excessive sugar. The woman needs to be aware of all the beverages and products that may contain caffeine. Besides caffeine she should consume less sugar, alcohol, and salt. Fat intake should be limited because fat builds hormones that cause breast tenderness and fluid retention. Exercising at least four times a week can help reduce symptoms of mood swings, increased appetite, crying, breast tenderness, craving for sweets, fluid retention, and depression by raising the beta-endorphin levels.

**163.** Which of these strategies would be most effective for nurses working to eliminate the practice of female circumcision in the world?

1. Work to pass laws prohibiting female circumcision.
2. Provide assistance to women seeking political asylum to prevent their daughters from being circumcised.
3. Promote general and health education in countries where female circumcision is practiced.
4. Encourage women to refuse to have their daughters circumcised.

(3) All of the options may have some benefit, but research has shown that when populations become more educated, there is increased legislation prohibiting the practice of female circumcision. In countries where female circumcision is practiced, it may not be possible for a woman to be considered for marriage without it. Efforts to establish a therapeutic relationship with the decision-making males of these cultures is necessary if any changes in the practice are made. Some women have successfully obtained political asylum to avoid the practice, but it is very difficult when it is the cultural norm of their home country. To refuse to allow a daughter to be circumcised may cause a life of abandonment and poverty for the child.

**164.** When a client has a genital lesion that is hard, nontender, red, sharply defined with indurated base, raised border, eroded surface and a scanty yellow discharge, a nurse should recognize these symptoms as indicative of:

1. herpes simplex.
2. human papillomavirus.
3. primary syphilis.
4. molluscum contagiosum.

(3) The lesion described is consistent with primary syphilis. Herpes simplex lesions are clear raised vesicles that are very painful. Human papillomavirus lesions are raised, polypoid masses with an irregular fingerlike surface and fissures. These warts are most commonly on the external genitalia of females and the penis of males. Molluscum lesions are clusters of raised, pearly white, firm nontender papules.

**165.** Which of the following clinical manifestations would the nurse utilize to distinguish between the sexually transmitted infections of Gonorrhea and Chlamydia?

1. site of infection at cervix
2. primary reservoir of cervix
3. incubation period of 8–21 days
4. presence of pelvic inflammatory disease

(3) Many sexually transmitted diseases have similar characteristics and complications. Those listed in this question are common to both gonorrhea and chlamydia except for option 3. The incubation period for chlamydia is 8–21 days, and it is 2–6 days for Gonorrhea. The cervix is the site of the major infection in females for both gonorrhea and chlamydia. In males the major site of infection is the urethra. In carrier states, the primary reservoir for both infections is the cervix.

The male urethra is a minor reservoir for both infections. Pelvic inflammatory disease is a local complication of both infections. Other common local complications for both infections include epididymitis, Bartholinitis, salpingitis, conjunctivitis, and proctitis.

**166.** When an adolescent male says to the school nurse, “I think I am gay,” the best response by the nurse would be:

1. “It’s too soon to know whether or not you are gay or straight.”
2. “Tell me what led you to believe this.”
3. “What makes you think you’re not heterosexual?”
4. “If you try dating girls, you might find you like it.”

(2) Option 2 gives the adolescent an opportunity to explore and discuss his feelings about the topic and to share with the nurse how he came to this conclusion. The nurse may be able to dispel myths about homo/heterosexuality in relation to the feelings or behaviors the youth is experiencing. This option is the most open-ended of all the options and allows for non-judgmental and continued discussion. Option 1 implies the youth must be wrong because he isn’t old enough to know. Research has shown that many homosexuals know even in their school-age years that they are gay. Although sexual identity may not be complete until late adolescence, the questions and discussion should not be ignored. Many adolescents change their self-labels of sexual orientation one or more times during their adolescence. Options 3 and 4 clearly imply to the adolescent that heterosexual is better or more appropriate and will shut down any further discussion.

**167.** When teaching clients about the effects of alcohol on sexuality, the nurse should include all of the following except:

1. small amounts of alcohol may increase the libido.
2. large amounts of alcohol enhance the reflexes involved in erection and ejaculation.
3. chronic use in women can decrease desire and orgasmic function.
4. chronic use in men can cause impotence and sterility.

(2) Large amounts of alcohol impairs the neural reflexes involved in ejaculation and erection. Small amounts of alcohol increase libido and decrease sexual inhibitions. Chronic alcohol use in women creates a decreased desire and orgasmic dysfunction. Chronic alcohol use in men causes impotence and sterility.

**168.** When teaching clients the effects of drugs on sexuality, which of the following information should the nurse include?

1. Some antihypertensives cause impotence in up to 50 percent of men.
2. Short-term use of cocaine inhibits the sexual experience.
3. Amyl nitrate causes less intense orgasms when inhaled at the time of orgasm.
4. Marijuana may increase sexual inhibitions.

(1) Antihypertensives decrease libido in both genders and can cause impotence and ejaculatory problems in up to 50 percent of men. Short-term cocaine use enhances sexual experience. Chronic use of cocaine causes loss of desire and sexual dysfunction in both sexes. Amyl nitrate is a peripheral vasodilator that can cause intensified orgasms when inhaled at the time of orgasm. Marijuana may decrease sexual inhibitions. Chronic marijuana use causes decreased libido and impotence.

**169.** When an elder client asks the nurse whether they will be capable of sexual activity in old age, the best response by the nurse would be:

1. “Older adults are psychologically and physically capable of engaging in sexual activity regardless of age-related changes.”
2. “If you haven’t been sexually active throughout your life, you will not be able to participate in sexual activity in old age.”
3. “When intercourse isn’t possible, many of your sexual needs can be met through intimacy and touch.”
4. “You may find it takes longer for you to achieve an erection, but you can maintain it for a longer time.”



(1) In order to provide the best response the nurse must identify what it is the elder is asking. Concern is being expressed about whether or not elders can engage in sexual activity. The most therapeutic response by the nurse is option 1. In this option the nurse acknowledges elders can physical engage in sexual activity and have no psychological barriers to the same. All other options contain facts but are not the best first response. Option 1 opens the conversation for the expression of further concerns about sexual issues. Option 2 is true; past sexual function is predictive of sexual function in older adults. An older adult must have been sexually active as a younger adult in order to engage in intercourse in old age. If this hasn't happened, though, it doesn't mean the older adult cannot experience sexual intimacy in other ways. The need for intimacy is especially important for older adults. If they have lost meaningful relationships or are having difficulty with intercourse, they may be able to experience intimacy through touch. As males age they will find it takes longer to achieve an erection but that once achieved the erection will last longer. In addition, older males require direct stimulation to achieve an erection.

**170.** When a client is experiencing ineffective sexuality patterns related to postpartum changes, which of the following interventions would be most effective to reduce dyspareunia?

1. Assess healing of episiotomy.
2. Encourage the woman to discuss her emotions.
3. Refer to the physician.
4. Reassure that this state is temporary.

(1) An episiotomy can cause pain on intercourse. To assess the healing of the episiotomy, the nurse must know that the incision heals on the surface after 1 week but that dissolvable stitches can take up to one month to heal. The nerves can remain sensitive and tender for as long as 6 months. Alternative positions for intercourse may help with the pain. Encouraging discussion of her emotions will not reduce pain on intercourse (dyspareunia). If the nursing interventions have not relieved the pain, a referral to the physician is appropriate. The pain probably is temporary but that will not be very comforting to the woman if other measures are not provided. If the pain is not temporary, then the client will have lost faith that the nurse is capable of helping her.

**171.** If a client has chronic renal failure, which of the following sexual complications is the client at risk of developing?

1. retrograde ejaculation
2. decreased plasma testosterone
3. hypertrophy of testicles
4. state of euphoria

(2) Untreated chronic renal failure causes decreased testosterone levels and atrophy of testicles, and decreased spermatogenesis. Retrograde ejaculation is not a complication of chronic renal failure. It is a complication of transurethral resection of the prostate. In chronic renal failure, the testicles atrophy, not hypertrophy. Chronic renal failure produces a state of depression not euphoria.

**172.** When working with multicultural populations, the nurse should consider all of the following when planning care for ineffective sexuality patterns except:

1. The Hispanic and Native American cultures are very open in discussing sexuality.
2. Some cultures view the postpartum period as a state of impurity.
3. Women in the African American culture view child-bearing as a validation of their femaleness.
4. Native American women believe monthly menstruation maintains physical well-being and harmony.

(1) Many cultures, including the Hispanic and Native American cultures, are very hesitant to discuss sexuality. The Navajo, Hispanics, and Orthodox Jews view the postpartum period as a state of impurity and may seclude the women as long as they are bleeding. They end the seclusion with a ritual bath. Option 3 is true. White teenage girls approve of prevention of pregnancy, and Indian teenage girls value pregnancy. Option 4 is true, Native American women believe in the importance of monthly menstruation to maintain physical well-being and harmony.

**173.** While seeking education about cancer prevention, a female client states “I eat a well-balanced diet; I do not smoke; I exercise regularly; and I have a yearly check up with my doctor. What else can I do to help prevent cancer?” The nurse should respond with which of the following statements?

1. Rest and sleep at least 6 to 8 hours a night.
2. Practice monthly self-breast examinations.
3. Reduce stress.
4. All of the above.

(4) All of the choices are methods of preventing cancer. Rest and sleep is important in the body’s homeostasis which aids in the body’s response to disease. Monthly breast examinations are helpful in determining breast changes that could indicate cancer or fibrocystic disease. The body has a physiological response to stress by decreasing the immune response, which can increase the client’s risk of developing cancer.

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

1. Provide her a copy of the approved dietary guidelines for the American Diabetic Association and the American Heart Association.
2. Ask the client to provide a list of the types of foods she eats to determine how to best meet her needs.
3. Provide a high-protein diet plan for the client.
4. Provide information related to risk factors for heart disease and diabetes.

(2) Assessing what the client eats based upon preference and culture will help the nurse determine a plan for dietary recommendations based upon the ADA and AHA diets. Providing the client with a copy of those guidelines is important; however, the client has stated that she is not sure how to adapt a plan for the types of food her family eats. Based upon the client’s wish to reduce her chances of heart disease and diabetes, a high-protein diet plan may not be appropriate. Providing information to the client related to risk factors for heart disease and diabetes is important to determine the client’s personal risk, but the client was seeking information related to how to modify her diet for disease prevention, and this should be addressed first.

**175.** A daycare center has asked the nurse to provide education for the parents regarding the safety in the home. What type of preventive care does this represent?

1. primary
2. secondary
3. tertiary
4. health promotion

(1) Primary prevention involves activities that are utilized to promote or prevent illness or injury. There are many dangers in the home for small children. Providing education regarding the need for safety measures to prevent injury in the home would be considered primary prevention. Secondary prevention involves early detection of a disease or illness, and quick intervention to aid the client in maintenance of the disease or injury. Tertiary prevention activities involve the reduction of a disability and the promotion of the highest level of functioning for the client in relation to their disease or injury. Health promotion is any activity that increases a client’s health and wellness.

**176.** A client has just returned from surgery where they performed a femoral-popliteal bypass. The nurse has assessed the client and is unable to feel a pulse at neither the dorsalis pedis nor the posterior tibial of the left foot. The foot feels warm, and the color is pink. What is the next action the nurse should perform in order to prevent ischemia?

1. Notify the physician immediately.
2. Obtain a Doppler device to check for pulses and notify the physician if they are still absent.
3. Wait 30 minutes and recheck the pulses.
4. Document the finding.

(2) The nurse should immediately obtain a Doppler device and recheck the pulses. The dorsalis pedis and posterior tibial may be difficult to assess, especially if not using a light touch, and may need to be verified with a Doppler. Since the client just had a surgery in which a complication is arterial insufficiency, the client must be monitored carefully. If the pulses are not found, the nurse should recognize that this is an emergent situation, and the physician must be notified right away. If the nurse waits 30 minutes before determining whether the pulses can be felt, this could compromise the viability of the client's foot due to ischemia. Documenting the findings is important but must be done after the nurse locates the dorsalis pedis and posterior tibial pulses, or after any necessary interventions are made.

**177.** A mother has come to the pediatric clinic concerned about the recent outbreak of West Nile Virus. The ages of her children are 5, 7, and 10. The mother has asked the nurse what she can do to prevent her children from contracting this illness. What information would be best to provide the mother with?

1. The children should wear long sleeves and long pants while outside.
2. Apply insect repellent containing DEET when the children are outside.
3. Remove standing water from the property.
4. All of the above.

(4) It is recommended that the children wear insect repellent containing DEET and long-sleeve shirts and long pants when they are outside. Removing standing water from areas around where the children play can help decrease the number of breeding mosquitoes. These are the only known methods of prevention at this time.

**178.** The home health nurse has recently made a visit to an 85-year-old female client's home who has recently had surgery to replace her left knee. The client has been at a rehab hospital and has been able to walk on her own. The nurse assesses the need for teaching related to fall prevention. What would the nurse include in this teaching plan?

1. The client should remove all scatter rugs from the floor and minimize clutter.
2. The client should not get up and move around the house.
3. The client will not need to install a raised toilet and grab bar since she is able to walk on her own.
4. The client should wear a robe and socks while walking in the house.

(1) Rugs and clutter are a primary cause of falls in the home and should be eliminated if possible to decrease the risk of a fall. The elderly and those with gait issues are at an increased risk for a fall at home. The client should have a raised toilet seat and grab bars available in the bathroom in order to aid in movement in this potential slippery area of the home. Some clients find it difficult to rise up and down from the toilet, and getting in and out of the shower may be difficult. These items are all important in maintaining safety in the home. The client should not limit their movement within the home unless ordered by the physician. This would decrease the ability of the client to perform activities of daily living and would hinder the client's return to a normal lifestyle after surgery. The client should not wear baggy clothing such as long robes, and the client should not wear socks on slippery floors. These items can cause the client to trip or slip and fall.

**179.** The leading cause of death in school-aged children is which of the following?

1. accidents
2. cancer
3. abuse
4. infection

(1) School-aged children are at high risk for injury resulting from accidents such as drowning, fires, motor vehicle accidents, and poisoning. This makes accidents the leading cause of injury and death in this age group. Chronic illnesses, abuse, and acute infections also take the lives of many school-aged children, but accidents are by far the most preventable cause of death in this age group.

**180.** While providing information regarding the prevention of accidents to the parents of preschool children, which of the following interventions can the nurse teach to aid in the prevention of child injury or death?

1. Preschool children should be able to swim with a peer.
2. Preschool children should be able to bike without a helmet on the sidewalk or in the backyard.
3. Preschool children may ride in the backseat without a seatbelt.
4. Preschool children should participate in a fire safety plan for the home.

(4) Children as young as preschool should participate in a fire safety plan for the home. Children can understand the concept of stop, drop, and roll and should be taught what to do in case of fire. A child in preschool should never go into the pool without the presence of an adult. The buddy system should be used for adolescents or young adults and is not appropriate for a preschooler. A child should always wear a helmet when playing on a bicycle, skates, or skateboards. Even if the child cannot come into contact with cars, they are at risk for head injuries from falls. Children should never ride in the backseat or any seat of the car without a seatbelt. Seatbelts should always be worn. Preschoolers should still be in a car seat or a booster seat. Determining whether a child should be placed in a car seat or a booster seat is dependent on the child's age and weight.

**181.** A new mother is scheduled to go home from the hospital this morning. The nurse is completing discharge planning with the client when the new mother states, "I am concerned that my baby will get sick if anyone touches her." What statement would be most appropriate to educate the client regarding the baby's immunity?

1. Babies are very resilient; she will be okay.
2. Babies are at high risk for developing infection until they are 3 months old.
3. Babies should be kept at home until after the first immunizations.
4. Visitors to your home should be discouraged until the baby is older.

(2) Newborn babies are at higher risk for developing infection until they are 3 months old. Babies have a limited immune system and are provided most of their antibodies through their mother's breast-milk. Education provided by the nurse should include information about protecting the infant during those first few months from large groups of people and individuals who are sick. It is not necessary to keep the baby home until after the first immunizations, and visitors should not be discouraged. However, it is important that those holding and caring for the baby practice good hygiene and hand-washing techniques.

**182.** The pediatric care nurse has received a call from a parent wanting to know whether he is doing the appropriate things to decrease his 5-year-old son's fever of 104°F. He states that Johnny was diagnosed with Varicella the day before at the doctor's office. The nurse asks the client to elaborate on the interventions he has taken with the child. He states that he has given the child a lukewarm bath and was about to give the child aspirin. Which is the most appropriate statement from the nurse?

1. You are doing a great job, continue with your plan, and let us know if Johnny's fever does not come down.
2. After you give the aspirin, place ice packs in Johnny's arm pits and in his groin.
3. Give the aspirin according to Johnny's age and weight and wait 30 minutes to see whether his temperature comes down.
4. Do not give aspirin to Johnny. He needs to have acetaminophen or ibuprofen to bring down his fever.

(4) Aspirin should not be given to a child with Varicella. Children with Varicella who are given aspirin have an increased incidence of developing Reyes syndrome. This syndrome causes acute encephalopathy. Ice packs will help bring down the fever, but the child should not be given aspirin or salicylates.

**183.** The nurse has just completed education regarding monthly self-breast examination with a 49-year-old African-American client. Which of the following statements would verify the clients understanding of breast disease prevention?

1. "I should perform this every few months at the same time each month."
2. "I should perform this every other month in the shower."
3. "I should perform this exam on the same day every month in the shower and lying down."
4. "If I notice a lump, I should watch it for a few months to see whether it grows."

(3) In order to determine the client understands the importance of this prevention strategy, they must understand that it should be performed monthly in the shower and lying down in order to accurately assess any changes in the breast tissue. Performing this examination every few months or every other month is not the best strategy for recognizing changes in the breast. By waiting to watch whether a lump grows, the client will put themselves at increased risk for the spread of cancer if the lesion is malignant. Any lump, dimple, or change in breast appearance or tissue should be reported to the physician immediately.

**184.** A 28-year-old male client with a bipolar disorder has been coming to the Mental Health Mental Retardation (MHMR) clinic for medication administration. This is an example of what type of prevention?

1. primary
2. secondary
3. tertiary
4. health promotion

(2) This client has been diagnosed with a psychological illness. Secondary prevention focuses on early detection and maintenance of the disease. Medication administration aids the client in reducing the effects of the illness and maintaining the client's psychological health. Primary prevention involves activities that are utilized to promote or prevent illness or injury. Tertiary prevention activities involve the reduction of a disability and the promotion of the highest level of functioning for the client in relation to their disease or injury. Health promotion is any activity that increases a client's health and wellness.

**185.** A client has been taking Lasix to prevent congestive heart failure. What other intervention can the nurse discuss with the client concerning dietary modifications?

1. Maintain low sodium intake.
2. Increase calcium intake.
3. Increase fiber intake.
4. Maintain low potassium intake.

(1) Clients who are at risk for congestive heart failure (CHF) should monitor the intake of salt. A low-sodium diet reduces fluid retention and vascular volume. This is important to prevent vascular overload and symptoms of CHF. Increasing calcium and fiber intake have no significant effect on the prevention of CHF. Clients placed on diuretics such as Lasix are at risk for hypokalemia. Clients should be placed on potassium supplementation and should not be on a low-potassium diet.

**186.** An elderly client is interested in starting an exercise program to prevent heart disease. The client wants the nurse to help him develop this program. What is the most important recommendation for the client?

1. Elderly clients should not participate in an exercise program.
2. Elderly clients should participate only in nonaerobic activity such as Tai Chi.
3. The client should use weights as well as aerobic activity.
4. The client should obtain clearance from a physician before beginning the program.

(4) All elderly clients who want to begin an exercise program should consult a physician for medical evaluation prior to starting the program. Elderly clients are at increased risk for developing problems from exercising, and a physician should determine what type of exercise is appropriate for the client. Although Tai chi is an excellent program for the elderly, if the physician determines the client's health allows, elderly clients may participate in aerobic exercise programs. Weights as well as aerobic activity may be used if the physician deems this appropriate.

**187.** The nurse is caring for a comatose client who is obese. What is the most important action the nurse can take in preventing back injury when caring for this client?

1. Wear a hospital provided back brace.
2. Obtain help from other staff members.
3. Equip the client's bed with an overhead trapeze.
4. Ask the nurse's aid to move the client.

(2) Obtaining help from other staff members is an essential component for safely moving a heavy patient. A back brace can help to support the back but cannot prevent back injury. This minimizes the risk for injury while moving the client. Staff members can work together to decrease the strain on any one individual. A nurse should never move a large client without help. An overhead trapeze would be an excellent intervention to aid the client in the ability to move on his own. This client is unable to move on his own based upon his cognitive function due to coma. Asking the nurse's aid to move the client is inappropriate. This would put the aid at risk for injury from moving the client.

**188.** A 5-year-old boy is scheduled for a left inguinal hernia repair in the operating room. Which of the following is not a sterilization method the staff would use to prevent postoperative infection?

1. autoclave
2. ethylene oxide
3. surgical scrub
4. radiation

(3) Although a surgical scrub is intended to remove all microorganisms, it is not considered a sterilization method. Autoclave (steam), Ethylene oxide (gas) and radiation are all methods of sterilization.

**189.** Which of the following clients should be checked for glaucoma more frequently?

1. a 30-year-old Asian American female with a history of myopia
2. a 39-year-old Native American female with a history of strabismus
3. a 46-year-old African American male with a history of myopia
4. a 53-year-old Caucasian male with a history of dry eyes

(3) African Americans of all ages are at greater risk for developing glaucoma than other ethnicities. Individuals 65 and older should also be checked more frequently for signs of glaucoma. Age, ethnicity, gender, and a history of strabismus or myopia do not play a significant role in the development of glaucoma.

**190.** A client with measles has been admitted to the medical-surgical unit. What precautions should the nurse take in preventing the spread of this disease?

1. airborne precautions
2. contact precautions
3. droplet precautions
4. standard precautions

(1) Highly contagious infections such as measles can be spread through the air and require airborne precautions. This includes the use of standard precautions and a mask every time the nurse or a visitor enters the room. The client should be placed in a negative pressure room, and movement within the room should be kept to a minimum. If the client is moved or transported outside the room, the client must wear a mask to prevent the potential for transmission. Contact precautions

require the use of gloves, gowns, and mask whenever providing care to the client and for visitors entering the room. Droplet precautions require the use of a mask if coming within three feet of the client. Standard precautions should be adhered to if there is potential for contact with blood or body fluids. Standard precautions require the use of personal protective equipment (PPE) such as gloves, gown, mask, and goggles if there is potential for exposure to blood and body fluid. The nurse or healthcare worker must determine what type of exposure could occur and use PPE accordingly.

**191.** A 30-year-old female client with a history of frequent urinary tract infections (UTI) has returned to the urologist with signs and symptoms of the illness. While at the office, the client asks the nurse, “How can I prevent myself from getting these infections?” What education can the nurse provide that would aid the client in preventing recurrent UTI’s?

1. Wear cotton underwear.
2. Urinate after sexual intercourse.
3. Drink at least eight glasses of water a day and maintain clear to straw-colored urine.
4. All of the above.

(4) Wearing cotton underwear allows air to keep the area dry and prevents bacterial growth. Urinating after sexual intercourse can remove bacteria that can travel through the urethra into the bladder resulting in a urinary tract infection. Drinking at least eight glasses of water a day and maintaining clear-to straw-colored urine through fluid intake helps flush bacteria from the urinary system and prevents urinary stasis, which can cause infection.

**192.** A client with *clostridium difficile* has been placed on contact precautions. The client’s spouse has stated that family will be coming to visit, and she does not want them to have to wear “all that gear.” What would be the appropriate response from the nurse?

1. Tell me your concerns with regards to your family wearing the protective equipment.
2. If your visitors will not wear gloves, gowns, and a mask, they can’t see your husband.
3. It is not necessary for them to wear the protective equipment.
4. If you don’t like the policy, then talk to the administrator.

(1) Assessing the spouse’s concern and educating the family regarding the need for the personal protective equipment should be the nurse’s response. This should show the family that the nurse cares not only for the client but for the family’s concerns. Telling the spouse that the visitors can’t see her husband will most likely upset her even more. Telling the spouse that the family does not have to wear the PPE is not appropriate. This can lead to the spread of the disease and be a direct result of contact with the client. Telling the spouse to talk to the administrator is not necessary unless after validating her concern and educating her regarding the need for the PPE, she wishes to speak to the administrator.

**193.** A client has been participating in alcoholics anonymous for 10 years. She has been sober for 8 years and 90 days. Continued participation in support groups such as alcoholics anonymous is an example of what type of prevention?

1. primary
2. secondary
3. tertiary
4. health promotion

(3) Tertiary prevention activities involve the reduction of a disability and the promotion of the highest level of functioning for the client in relation to their disease or injury. Support groups such as alcoholics anonymous encourage the client to function with the disease and help prevent disabling episodes of illness.

Primary prevention involves activities that are utilized to promote or prevent illness or injury. Secondary prevention involves early detection of a disease or illness and quick intervention to aid the client in maintenance of the disease or injury. A back brace can help to support the back but cannot prevent back injury.

**194.** While managing a pediatric healthcare clinic, Sally noticed that she had many staff absences due to illness. Sally decides to present an in-service presentation on illness prevention. What is the most important method of illness prevention that should be highlighted in her presentation?

1. wearing gloves while taking vital signs
2. wearing a mask with sick children
3. frequent hand washing
4. using antiseptic cleanser after each client

(3) Wearing gloves while taking vital signs is only necessary when encountering blood or body fluids and is not the most important method of preventing illness. Wearing a mask with sick children is only necessary when encountering highly contagious illnesses such as measles and Varicella. Using antiseptic cleanser, although effective in removing infectious agents, should be used only when running water, and soap is unavailable for hand washing. Frequent and effective hand washing will remove most organisms from the skin. Contaminated hands are the primary cause of disease transmission.

**195.** While caring for a client with an HIV-related illness, the nurse should use what type of precautionary measures?

1. standard precautions
2. gloves and gown
3. gloves, gown, and mask
4. no precautions

(1) Gloves and mask or gloves, gown, and mask would be necessary only if coming in contact with blood or body fluids. Personal protective gear would not be necessary for every interaction with this client. Using no precautions could put the nurse at risk for contracting HIV. Standard precautions allows the nurse to choose the protective gear based upon the potential contact with blood or body fluids and the type of interaction with the client.

**196.** While taking a family history, the nurse notes that the 35-year-old female client has a history of hypertension in her family. Both her mother and father have been diagnosed with the illness. Although the client has not shown any symptoms of this illness, what should the nurse include in her teaching regarding prevention of this disease?

1. Increase sodium intake.
2. Take her blood pressure twice a day.
3. Eliminate all stress from her life.
4. Participate in a low- to moderate-intensity exercise program.

(4) Increasing her sodium intake could put her at higher risk for developing hypertension. Taking her blood pressure twice a day is an unnecessary measure if the client has shown no symptoms of hypertension. Instructing the client to strive to limit stress is important, however, eliminating all stress from a client's life is not realistic. Participating in a low- to moderate-intensity exercise program is the best prevention at this point in the client's life.

**197.** What is the nurse's primary responsibility when following standard precautions to care for a client?

1. Wear gloves and a mask when caring for a client who has diabetes mellitus.
2. Place a sign on the door stating body substance isolation precautions.
3. Consider all blood or body fluid a potential for containing infectious agents.
4. Wear gloves whenever in contact with the patient.

(3) Wearing gloves and a mask when caring for a client with diabetes mellitus is unnecessary, unless there is the potential for contact with blood or body fluids. Placing a sign on the door stating body substance isolation precautions is not necessary when caring for clients. Wearing gloves whenever in contact with the patient is not necessary unless the nurse assesses a potential for contacting blood or body fluids. If working in a facility that uses latex gloves, continued exposure can increase the potential for the nurse to develop a latex allergy. All clients' blood or body fluids should be considered a potential for transmission of infectious agents.



**198.** Infectious agents that cause the most nosocomial infections are which of the following?

1. fungi
2. viruses
3. protozoa
4. bacteria

(4) Bacteria are the number one cause of nosocomial or hospital-acquired infections. Prevention of transmission of bacteria and other infectious agents can be accomplished through frequent hand washing, disinfection, and cleaning as well as disposing of trash and linens appropriately. Infection control processes are essential in preventing the spread of disease through a healthcare facility.

**199.** The nurse has just completed a teaching session regarding the risk factors for coronary artery disease for a 45-year-old male client. The nurse asks the client to verbalize the modifiable risk factors for the disease. Which of the following is the correct response?

1. cholesterol, menopause, and obesity
2. heredity, smoking, and diabetes
3. cholesterol, obesity, and smoking
4. hypertension, gender, and obesity

(3) Cholesterol, obesity, and smoking are all considered modifiable risk factors. Other modifiable risk factors include hypertension and diabetes. Modifiable risk factors are those factors that can be monitored and changed by a client to decrease the client's risk of developing coronary artery disease. Other factors such as age, race, menopause, heredity, and gender are considered nonmodifiable risk factors, or those that cannot be changed.

**200.** A 40-year-old female client has been admitted to the medical-surgical floor for acute bronchitis. During the nursing assessment, it is noted that the patient's mother and father have both died of COPD, and the client admits to smoking a pack of cigarettes a day. What is an important first step in preventing the client from developing COPD?

1. Determine the client's level of interest in smoking cessation programs.
2. Prevent the client from smoking while in the hospital.
3. Teach the client to deep breathe and cough frequently.
4. Administer supplemental oxygen at 4L/min. via nasal cannula as per the physician's order.

(1) Determining the client's level of interest in a smoking cessation program is the most important first step in preventing chronic respiratory illnesses such as COPD. Smoking is associated with many pulmonary illnesses; however, the client must be ready and willing to participate in a cessation program in order to aid in prevention of these illnesses. Although preventing the client from smoking while in the hospital for bronchitis may help in the healing process, the client must stop smoking in order to prevent further pulmonary disease. Teaching the client to deep breathing and cough frequently may help with oxygenation and healing from the present pulmonary illness but will not prevent the development of COPD. Administering supplemental oxygen may aid in the healing process but will not prevent the development of COPD.

**201.** During the nursing history of a 51-year-old female client, the client states that her father and aunt were treated for colon polyps. The client states that she has never had any trouble with her GI system. What test is important in the prevention of colon cancer and should be administered yearly starting at the age of 50?

1. barium enema
2. upper GI series
3. flexible sigmoidoscopy
4. esophagogastroduodenoscopy

(3) A flexible sigmoidoscopy is essential in all clients over the age of 50 for the detection of abnormal growths or polyps in the colon. If a client has significant risk factors or a familial history of colon cancer, the physician may order a colonoscopy. An upper GI series and an esophagogastroduodenoscopy (EGD) is a radiological test for detecting

abnormalities of the esophagus, stomach, and duodenum but is not the recommended test for detecting colon cancer. A barium enema may show lesions in the colon but is not the test of choice for clients with no previous symptoms or history of GI problems.

**202.** Which of the following are major ways that the family carries out its healthcare functions?

1. Family provides very little preventive healthcare to its members at home.
2. Family provides the major share of sick care to its members.
3. Family pays for most health services whether or not received.
4. Family decides when and where to hospitalize its members.

(2) The healthcare function is not only an essential and basic family function but one that assumes a central focus in healthy, well-functioning families. However, fulfilling the healthcare function for all family members may be difficult due to external and internal challenges. Research suggests that the reasons families have difficulties providing healthcare for their members lie with both (a) the structure of the family structure and (b) the healthcare system. Research found that when families had wide associations with organizations, engaged in common activities, and used community resources, they used healthcare services more appropriately. Also, personal health practices were enhanced when husbands were actively involved in internal family affairs, including matters concerning the healthcare system.

**203.** What is the primary factor that influences a family's conceptualization of health and illness?

1. Health Belief factor
2. Education-School-Completing factor
3. Family Health Expert factor
4. Disconnected Family factor

(1) The primary health belief model shows that the readiness factors have been extended to include both the perceived feelings of the susceptibility and seriousness of the health problem (the threat) and positive motivation to maintain, regain, or attain wellness.

**204.** American families were not adequately performing their vital healthcare function. What are the basic reasons for this inadequacy?

1. structure of the healthcare system and the family structure
2. psychological factor for men and women seeking healthcare
3. a condition is labeled a disability and is too time consuming
4. healthcare systems (HMO) and disconnected families

(1) Pratt suggested that the reasons why families are having difficulty providing healthcare for their members lies with both (1) the structure of the healthcare system and (2) the family structure. Major factors explaining differences in utilization patterns of medical services include the lack of healthcare insurance coverage, lack of services for special populations (for example, teenage males), the perception by families of the healthcare system and the healthcare provider, and the lack of partnership between the healthcare provider and the family in mutually addressing healthcare issues.

**205.** Kleinman's Explanatory Model of Health and Illness is significant because:

1. it explains what kind of health beliefs a family is likely to have.
2. it brings out the importance of culture in forming health explanations.
3. it discusses the important role that popular and folk domains of influence have.
4. it has an educational base to the structure.

(3) The anthropologist Kleinman makes a distinction between disease and illness. Disease is the healthcare professionals' biomedical understanding of the health problem, while illness is the patient's personal and unique understanding and definition of what is happening to him or her. The authors state that cultural factors determine the importance of the various domains of influence.

**206.** Which of the following substances constitute drugs that need to be assessed by the family completing a family health assessment?

1. coffee, tea, cola, and cocoa
2. alcohol, fruit juice, and eggs
3. medicines prescribed by physician
4. tobacco, chewing gum, and mints

(1) When assessing drug, alcohol, and tobacco practices among family members, a thorough investigation of prescribed, over-the-counter, and illegal substance use practices should be made. Assessment of dietary practices should include the amount and types of food the family eats, the social behaviors associated with dietary practices, and the meal planning, shopping, and preparation practices of the family.

**207.** An appraisal of self-care practices involves an assessment of:

1. all diagnostic tests.
2. home treatment practices, including nurse visits for the sick or disabled.
3. determination of the family's ability to get health insurance.
4. care giving needs and the potential for strain.

(4) Short-term stressors impinging on the family: husband's unemployment; being on welfare and then the threat of termination; all health, hospitalization, and convalescence; and depression and suicidal thoughts. Long-term stressors impinging on the family: emotional distance and lack of communication in family and especially within marital relationship; continual geographical movement, from one community to the next, so that no stable and sufficient social network is established; and husband's minimal participation in family life and his excessive and frequent drinking bouts. Family strengths: presence of social support system; interest in and ability for child care; motivation for employment and to be financially self-sufficient; self-care beliefs and values; health-seeking behaviors and realistic goals and limitations.

**208.** Which of the following are examples of complementary or alternative care practices:

1. massage, nutritional supplements.
2. Atkins diet, biofeedback.
3. acupuncture, mood stabilizing drugs.
4. health foods, fluoride water.

(1) Complementary or alternative care practices include: acupuncture, acupressure, aromatherapy, biofeedback, healing touch, herbal supplements, home remedies, hypotherapy, lifestyle diets, manipulation (chiropractic, osteopathy), massage, meditation, megavitamins, nutritional supplements, pastoral/spiritual counseling, relaxation therapy.

**209.** Safety measures under environmental practices identify major areas of health advice related to the family. What are they?

1. Store all powders, chemicals, and liquids in lower cabinets where they can be reached.
2. Save all prescribed medications for possible later use.
3. Always follow the manufacturer's warning on cleaning solutions, powders, or chemically treated materials.
4. Never buy any solutions that can hurt the family.

(1) Always follow the manufacturer's warning on cleaning solutions, powders, or chemically treated materials. Store toxic, abrasive, or caustic substances properly and out of the reach of young children. Do not save and reuse old prescribed medicines.

**210.** Which of the following is a general health education area for families to learn about concerning dental health?

1. Brush your teeth whenever you think of it.
2. Always live where there is fluoride and iron in the water.
3. Carbohydrates and fats cause all tooth decay.
4. Effective teeth brushing and flossing.

(4) Dental health includes: importance of fluoride for increasing resistance of tooth decay, importance of brushing and flossing teeth (and use of an effective method of brushing), role of carbohydrates (starches and sugars) in producing dental caries, importance of regular dental examinations and cleaning of teeth, and early treatment of dental caries and treatment of major orthodontic problems.

**211.** Which of the following measures are generally recommended for plaque?

1. toothbrushing with a special toothpaste
2. reduction in dietary sucrose, potatoes, and carrots
3. daily flossing of teeth with a ribbon dental floss only
4. use of a mouthwash twice a day

(4) A mouthwash with a preparation of plain peroxide in water 4:1 will kill the organisms in the mouth instantly and reduce the chances of plaque.

**212.** What is the most important nutritional history the nurse should elicit?

1. cultural, food patterns, and psychological aspects
2. food preferences, physiological aspects, manners
3. manners, shopping style, food-frozen meals
4. cultural, quantity, height/weight and desires

(1) For a nutritional history (the three-day family food record), observe for variations among family members in terms of quality and quantity of diet, height/weight/body build of family members, identify any special family food preferences (culturally, philosophically, or trend-based dietary food patterns), note the psychosocial aspects of mealtimes and eating (food used as a reward of punishment), and note the shopping, planning, and food preparation characteristics.

**213.** What behavior-specific factors are the primary motivational mechanisms for engaging in health-promoting behavior?

1. interpersonal relationships with friends and relatives
2. social-cultural factors that are present by outside groups on the family practices
3. self-esteem, follow all healthcare practices
4. perceived benefit of action, situational influences, and personal commitment to a plan

(4) Six behavior-specific cognitions and affect factors are identified in the model as the primary motivational mechanisms for engaging in health promoting behavior. They are (1) perceived benefits of action, (2) perceived barriers to action, (3) perceived self-efficacy, (4) activity-related affect, (5) interpersonal influences, such as family and peers, and (6) situational influences. Individual characteristics and experiences (including the effect of prior related behavior and personal biological, psychological, and sociocultural factors) are thought to contribute to activating these six behavior-specific cognitions and to directly impact on health-promotion behaviors. Additionally, the likelihood of a person engaging in health-promoting behaviors is conceptualized as being influenced by a person's sense of commitment to a plan of action with specific strategies and the ability of the person to balance competing demands and preferences.

**214.** Physical activity for individuals should be:

1. whenever a person wants to.
2. never, unless the doctor tells you to do exercise.
3. every day for at least 30 minutes.
4. every day for at least 1–2 hours.

(3) Individuals are recommended to participate in 30 minutes a day or more of moderate physical activity on most, preferably all, days of the week. This activity can and should include recreational activities shared with other family members.

**215.** Family hygiene and cleanliness practices should include:

1. daily showers with good soap.
2. good personal hygiene, hand-washing.
3. hand-washing and use of old eating utensils from the family shared.
4. cleanliness by washing the body with prescribed preparations.

(2) The family's hygiene and cleanliness practices should include good hand-washing and good personal hygiene and should discourage the sharing of food and utensils.

**216.** Medically based preventive measures employed by the family should include:

1. daily baths, home care, dental care.
2. annual exams by all family members, all family on the same diet.
3. seeking dental and vision care.
4. all family having hearing testing and total healthcare screening.

(3) Medically based preventive measures employed by the family include completing an annual physical examination, seeking vision and hearing screening, seeking regular dental care, and ensuring that all family members are immunized.

**217.** Pratt stated that American families were generally inadequate in carrying out healthcare function based upon which of the following observations?

1. politics not with proper healthcare of the citizens
2. over abundance of distractions available to people
3. healthcare not important to most families
4. level of health knowledge inadequate; widespread unhealthful personal and family health practices

(4) Pratt concluded that America families were generally inadequate in carrying out their healthcare function based on the following observations: many homes were not suitable for maintaining health and controlling infectious disease and accidents (crowdedness, safety hazards, pollution, lack of infectious disease control); widespread unhealthful personal and family health practices; medication misuse widespread; dependent and/or disabled family members not cared for or inadequately cared for; insufficient or inappropriate use of health services found frequently; level of health knowledge inadequate; and family's self-care practices not satisfactory. Reasons for this inadequacy are basic structure of the healthcare system (healthcare provider dominated; bureaucratic structure), family structure itself (family needs to be more widely involved with community and husband-fathers need to be actively involved), and lack of access to due lack of health insurance.

**218.** Healthcare practices include:

1. herbs, acupressure, socialization.
2. home remedies, massage, care at home only.
3. dietary, exercise, use of medically based interventions.
4. dietary restrictions of fats, recreational activities, church socials.

(3) Healthcare practices include dietary practices, sleep and rest practices, exercise and recreational practices, therapeutic and recreational drug use, self-care practices, hygiene practices, use of medically based interventions, and use of complementary and alternative therapies.

**219.** Important societal changes/issues affecting child rearing include:

1. daycare for working mothers in excellent facilities.
2. single-parent families with guilt feelings.
3. conflicting information from “experts” on how to raise children.
4. abuse/neglect not an important issue.

(3) Several important societal changes/issues affecting child rearing include: daycare for children of working mothers and their feelings of guilt about working and dissatisfaction about the facilities available, the growing number of single-parent families and how well this type of family can fulfill the socialization function, the growing number of stepparent families and the complex parenting problems this family form faces, methods or approaches for assisting families where child abuse or neglect exists, the emphasis on “unisex” upbringing and its consequences, and conflicting information from “experts” on how to raise children.

**220.** Attitudes or beliefs that limit family effectiveness include:

1. rigid values and beliefs.
2. not aware of political influences.
3. medical belief that all healthcare is bad.
4. environment beliefs that one must have an owned house for the family.

(1) Attitudes or beliefs that limit family effectiveness include: strong beliefs that orderliness, neatness, obedience, degree of restraint, or assertiveness are desirable and should be important to everyone; rigid values and beliefs that hold that there is a “right and proper” way to raise children; religious convictions suggesting that certain customs and techniques are “good” and others are “bad” or “sinful;” the belief that the mother or parents are solely responsible for their children’s behavior (blaming the parents); and the attitude that the family’s situation is not relevant, or is less significant, whereas “what is best for the child” should be the focus (excluding consideration of the constraints of the family’s environment).

**221.** The major factor in access to healthcare and utilization patterns of medical services is:

1. Medicaid.
2. Medicare.
3. lack of healthcare insurance.
4. National Center for Health Services.

(3) Access to healthcare as well as utilization patterns of medical services is healthcare insurance coverage.

**222.** One of the components of antepartal nursing care is provision of childbirth education classes (health promotion). What is the main objective of most childbirth education programs in the United States?

1. a painless childbirth experience
2. the participation of both parents in the birth process
3. the elimination of medication in labor and delivery
4. an emotionally satisfying birth experience

(4) Childbirth classes are designed to increase clients’ understanding of pregnancy and birth and to promote the optimum health of mother and baby. Through the use of relaxation and other techniques, pregnant women are helped to cope better with labor and achieve an emotionally satisfying experience. The father of the baby is not always available to participate in the birth experience; successful prepared childbirth is not solely dependent on this participation. Pain-free birth and avoidance of analgesia or anesthesia are not main objectives of childbirth education

**223.** A client asks for information on dietary requirements, including the best sources of carbohydrates, fats, and protein. What facts do you provide?

1. all low-carb foods
2. good sources of protein only
3. recommended daily caloric intake including all sources required
4. all minerals and vitamins

(3) Experts recommend that 10–20 percent of a person’s daily caloric intake comes from protein; about 30 percent from fat; and 50–60 percent from carbohydrates. Protein-rich foods include poultry, fish, meat, eggs, milk, and cheese (complete proteins) as well as some vegetables and grains (incomplete proteins). Fats are found in vegetable oils and animal fats. Carbohydrates, which are ingested as starches (complex carbohydrates) and sugars (simple carbohydrates), are the chief protein-sparing ingredients in a nutritionally sound diet. In general, the diet should include more calories from complex carbohydrates, such as rice, bread, and legumes, than from simple carbohydrates, such as sugar, cookies, and candy. Excessive carbohydrate intake—especially of simple carbohydrates—can cause obesity, predisposing a person to many disorders.

**224.** What factors contribute to malnutrition in elderly clients?

1. lack of water supply and no friends
2. poorly fitting dentures and limited mobility
3. critical issues in family affairs
4. no drugs but tobacco smoking

(2) Poorly fitting dentures, which can decrease nutritional intake and limit variety in diet; physical disabilities that limit mobility and, therefore, the ability to obtain, prepare, or eat food; nutritionally inadequate diet of soft, refined foods that are low in residue and dietary fiber; social isolation.

**225.** Karen McNulty, age 18, is pregnant and comes to the prenatal clinic for a checkup. Because of her age and condition, Mrs. McNulty is at nutritional risk. What health history questions would you ask Mrs. McNulty to assess her nutritional status?

1. “Are you unhappy?”
2. “Do you have a support person to cook for you?”
3. “Have your eating patterns changed?”
4. “Are you married?”

(3) How have your eating patterns changed since you have become pregnant? Are you taking any nutritional supplements, such as vitamins? How has your weight changed since you have become pregnant? Are you currently breastfeeding another baby? What do you eat in a typical day (24 hours)? What snacks and fluids do you consume? Do you use any alcohol, drugs, tobacco, caffeine (coffee, tea, cola, or cocoa), or salt? If so, what effects do they produce? Do you follow any special diets?

**226.** What assessment techniques are used to determine a client’s nutritional status?

1. inspection and palpation
2. palpation and percussion
3. laboratory and percussion
4. auscultation and ballottement

(1) Inspection and palpation are the assessment techniques used to assess a client’s nutritional status. The nurse should inspect the client’s skin, hair, and nails (integumentary system) as well as posture, muscles, and extremities (musculoskeletal system). The nurse should also inspect the oral structures, eyes, and thyroid gland; and palpate to detect enlarged glands, such as the thyroid (endocrine system), liver (gastrointestinal system), and spleen (immune system).

**227.** Susan Hammer, age 75, is admitted to the orthopedic unit for fractured hip repair. Because the stress and immobility associated with this injury, Ms. Granger is at increased risk for developing which metabolic disorder?

1. negative nitrogen balance
2. hyperlipidemia
3. hypoglycemia
4. anabolism

(1) Negative nitrogen balance may result from inadequate dietary protein intake, inadequate quality of ingested dietary protein, or excessive tissue breakdown following stress, injury, immobility, or disease.

**228.** During the health history, the nurse asks basic questions that assess nutritional health. Based on Ms. Hammer's developmental status, which additional questions should the nurse ask?

1. "Do you wear dentures?"
2. "What are your food preferences?"
3. "Do you have any food allergies?"
4. "Who prepares your meals?"

(1) The nurse should ask an elderly client about denture wear and fit. Poorly fitted dentures may decrease an elderly client's nutritional intake, contributing to nutritional deficiencies.

**229.** Which assessment technique helps determine protein and fat reserves?

1. height and weight measurements
2. anthropometric arm measurements
3. chest circumference measurements
4. head circumference measurements

(2) Midarm circumference, triceps skinfold thickness, and midarm muscle circumference provide a way to determine the amount of skeletal muscle and adipose tissue, which indicate protein and fat reserves.

**230.** Ms. Blackburn brings her daughter Becky, age 4, for her annual checkup. The nurse plots Becky's height and weight on a pediatric growth grid. Normal growth is represented by which range of percentage?

1. 50–100th percentile
2. 25–75th percentile
3. 10–100th percentile
4. 5–95th percentile

(4) Measurements that fall between the 5th and 95th percentiles represent normal growth for most clients. The weight and height chart is done on each child to help determine growth patterns.

**231.** Health promotion activities are designed to help clients:

1. reduce the risk of illness.
2. maintain maximal function.
3. promote healthy habits related to healthcare.
4. all of the above.

(4) Health promotion activities are designed to help clients: Reduce the risk of illness, maintain maximum function, and promote health habits related to healthcare. The basic components of health maintenance are health and disease prevention. Health-Promotion activities are approach behaviors that seek to expand the potential for health and are often associated with lifestyle choices; Disease-Prevention activities are avoidance behaviors that seek to prevent specific diseases or conditions. Health-Promotion behaviors enhance overall well-being.



**232.** Rehabilitation services begin:

1. when the client enters the healthcare system.
2. after the client requests rehabilitation services.
3. after the client's physical condition stabilizes.
4. when the client is discharged from the hospital.

(1) Rehabilitation services should begin when the client enters the healthcare system. Health maintenance opportunities should begin with an assessment of where the client is at the time of admission; devising a plan of care; and providing interventions /evaluations throughout the institutional stay.

**233.** An example of an extended care facility is:

1. home health agency.
2. suicide prevention center.
3. state-owned psychiatric hospital.
4. nursing facility.

(4) When an older client has been hospitalized for an illness, under Medicare they can be transferred to a nursing facility. An extended care facility provides an opportunity for the client to have nursing care to enable the client to rehabilitate in a supervised manner.

**234.** A client and his or her family, facing the end stages of a terminal illness might be best served by a:

1. rehabilitation center.
2. extended care facility.
3. hospice.
4. crisis intervention center.

(3) Hospice has the belief that a more humanized alternative care for the dying client than being provided by the hospital, which focused mostly on medical cure. No matter where the care is delivered, a specialized interdisciplinary team of healthcare professionals works together to manage the patient's care. Hospice programs provide comfort care, and also help patients and families to obtain a degree of mental and spiritual preparation for death that is in accordance with their wishes. Clients in the facilities of the rehabilitation center, extended care center, and the crisis center have a different object from Hospice care in that they provide care to help the client to return to society in hopefully a higher level of health.

**235.** Which one of the following is one of the main, overarching goals for *Healthy People 2010*?

1. reduction of healthcare costs
2. elimination of health disparities
3. investigation of substance abuse
4. determination of acceptable morbidity rate

(2) *Healthy People 2010* has elimination of health disparities among the U.S. population as its main goal. *Healthy People 2010* has as a main goal –Quality of Care for all populations. The nurse is at the forefront to provide the needed care no matter what setting the client is in. The individual should be considered on an individual basis, considering all facets presenting. Disparities exist: Individuals, Communities, and Health Facilities. These should be linked together (no fragmentation of services).

**236.** The client is a paraplegic and is in the hospital to be treated for an electrolyte imbalance. Which level of care is the client currently receiving?

1. primary prevention
2. secondary prevention
3. tertiary prevention
4. health promotion

(2) Secondary prevention. The current focus of healthcare is on preventive care. Leavell and Clark (1965) described the three levels of preventive care as primary, secondary, and tertiary. Secondary preventive care focuses on early detection of disease, prompt intervention, and health maintenance for patients experiencing health problems. Examples of activities at this level are carrying out direct nursing actions (for example, providing wound care, giving medications, or exercising arms and legs); assessing children for normal growth and development; and encouraging regular medical and dental screenings and care. Primary preventive care is directed toward health promotion and specific protections against illness. Activities at this level may focus on individuals or groups. Examples of primary-level activities are immunizations, family planning services, teaching breast self-examination, poison-control information, and accident prevention education. Tertiary preventive care begins after an illness is diagnosed and treated and is aimed at helping rehabilitate patients and restore them to a maximum level of functioning.

**237.** Which of the following nursing activities is an example of tertiary level preventive care?

1. teaching a client how to irrigate a new colostomy
2. providing a class on hygiene for an elementary school class
3. informing a client that immunizations for her infant are available through the health department
4. arranging for a hospice nurse to visit with the family of a client with cancer

(4) Tertiary preventive care begins after an illness is diagnosed and treated and is aimed at helping rehabilitate patients and restore them to maximum level of functioning. Nursing activities on a tertiary level include teaching a patient with diabetes how to recognize and prevent complications and referring a woman to a support group after removal of a breast because of cancer.

**238.** In the HEALTH-Healing/Disordering model, the nurse recognizes that the achievement of health is a process that includes:

1. choosing and balancing.
2. functioning in all dimensions.
3. complying with healthcare therapies.
4. participating in health promoting behaviors.

(1) The HEALTH-Healing/Disordering model recognizes that the achievement of health is a process that includes choosing and balancing. The emphasis of this model recognizes the unique interaction of the person's mind, body, and spirit within the environment. The use of lifestyle modification skills that alleviate stress and promote a state less susceptible to disease. These are chosen by the individual and should be balanced with positive behavior/health/healing.

**239.** Healthcare costs rose dramatically from 1965 to 1985 as a result of:

1. medical malpractice.
2. increased numbers in the work force.
3. an increased incidence of acute disease.
4. a growing aged population.

(4) The goals of *Healthy People 2010* reflect the nation's changing demographics: Increase quality and years of "healthy life" indicates the aging or "graying" of the population.

**240.** An example of a health promotion service is a(n):

1. immunization clinic.
2. breast self-examination clinic.
3. aerobic dance class.
4. smoking cessation clinic.

(3) Health promotion interventions limit progression of disease and/or avoiding disease in the future. It increases well-being. Besides aerobics, there are many activities that support this.

**241.** Care management is an innovative approach to delivering healthcare. The major factor for its success is that it:

1. focuses on the process.
2. uses outcomes to manage client care.
3. is used exclusively in the acute care setting.
4. allows a high degree of flexibility for the nurse delivering care.

(2) Case management uses outcomes to manage client care. A nurse works with a multidisciplinary healthcare team to measure the effectiveness of the care management plan and monitor outcomes. The case manager is usually a nurse who is in a direct line with the client. Besides monitoring outcomes, the nurse can provide support and education to the individual and family.

**242.** Case management is one strategy for coordinating healthcare services. What best describes this care-giving approach?

1. It is designed for clients requiring minimal to moderate levels of care.
2. Continuity of care is the primary concern.
3. The physician is the coordinator of client care.
4. This focus of care may be more expensive.

(2) The case manager monitors outcomes, after developing a professional health team plan. This plan enables the client and family to be a part of their care as well as other health team members.

**243.** A student nurse visiting a nurse-managed clinic should expect to see which of the following services offered?

1. same day surgery
2. family support services
3. ongoing psychiatric therapy
4. physical therapy

(2) Managed care is a method of organizing care delivery that emphasizes communication and coordination of care among all healthcare team members. The other options may be a part of the clinic, but is not the primary nurse function in this situation.

**244.** An individual who lives in a large city is interested in personally improving the healthcare of his community. Which nurse-client intervention setting would best fulfill his needs?

1. volunteer agency
2. occupation health setting
3. public health department
4. neighborhood health center

(4) The neighborhood health center has a population of clients who live in a certain area, and continuity of care may be a feature. These centers offer many important healthcare needs of the specific population.

**245.** The payment mechanism that Medicare uses within its healthcare financing is:

1. capitation.
2. fee-for-diagnosis.
3. fixed payment.
4. direct contracting.

(2) With Medicare, which is a government-funded program, there are two parts, A and B. Part A is part of the plan that covers hospitalization; and Part B is voluntary, paid by the individual, and covers the doctors' fee as well as other diagnostic studies.

**246.** Focus areas of the *Healthy People 2010* are:

1. hospital care.
2. home care.
3. community-based programs.
4. private care.

(3) The 28 focus areas in *Healthy People 2010* are: access to quality health services; arthritis, osteoporosis, and chronic back conditions; cancer; chronic kidney disease; diabetes; disability and secondary conditions; educational and community-based programs; environmental health; family planning; food safety; health communication; heart disease and stroke; HIV; immunization and infectious diseases; injury and violence prevention; maternal, infant, and child health; medical product safety; mental health and mental disorders; nutrition and overweight; occupational safety and health; oral health; physical activity and fitness; public health infrastructure; respiratory diseases; sexually transmitted diseases; substance abuse; tobacco use; and vision and hearing. These focus areas can best be achieved in a community center where a specific population lives. The adjustment of the goals can more easily be accomplished in a smaller setting.

**247.** The leading health indicators in *Healthy People 2010* are:

1. hospital care.
2. home care.
3. environment care.
4. emergency room care.

(3) The leading health indicators in *Healthy People 2010* are as follows: Physical activity—regular physical activity throughout life is important for maintaining a healthy body, enhancing psychological well-being, and preventing premature death. Overweight and obesity—overweight and obesity are major contributors to many preventable causes of death. On average, higher body weights are associated with higher death rates. The number of overweight children, adolescents, and adults has risen over the past four decades. Tobacco use—cigarette smoking is the single most preventable cause of disease and death in the United States. Substance abuse—alcohol and illicit drug use are associated with many of this country's most serious problems, including violence, injury, and HIV infection. Responsible sexual behavior—unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus that causes AIDS, can result from unprotected sexual behaviors. Mental health—approximately 20 percent of the U.S. population is affected by mental illness during a given year; no one is immune. Of all mental illnesses, depression is the most common. Major depression is the leading cause of disability and the cause of more than two-thirds of suicides each year. Injury and violence—more than 400 Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, falls, fires, and drowning. Environmental quality—an estimated 25 percent of preventable illnesses can be attributed to poor environmental quality. Two factors of air quality are ozone (outdoor) and environmental tobacco smoke (indoors). Immunization—vaccines are among the greatest public health achievements of the twentieth century. Immunizations can prevent disability or death from infectious diseases for individuals and can help control the spread of infections within communities. Access to healthcare—strong predictors of access to quality healthcare are having health insurance, a higher income level, and a primary care provider or other source of ongoing healthcare. Use of clinical preventive services, such as early prenatal care can serve as indicators of access to quality healthcare services. The entire behaviors above become environmental concerns of the individual, family and the community.

**248.** Health promotion programs are usually found in many settings. The major setting(s) are:

1. home or community settings.
2. hospital settings.
3. outside settings.
4. none of the above.

(1) Programs and activities may be offered to individuals and families in the home or in the community setting and at schools, hospitals, or worksites. Some individuals may feel more comfortable having a nurse, diet counselor, or fitness expert come to their home for teaching and follow-up on individual needs. This type of program, however, is not cost effective for most individuals. Many people prefer the group approach, find it more motivating, and enjoy the socializing and support. Most programs offered in the community are group oriented.

**249.** School health promotion programs may serve the community. They are for:

1. children—gain knowledge about personal hygiene and other health issues.
2. teachers only—health.
3. parents only—health.
4. employees only—health.

(1) School health-promotion programs may serve as a foundation for children of all ages to gain basic knowledge about personal hygiene and issues in the health sciences. Because school is the focus of a child's life for so many years, the school provides a cost-effective and convenient setting for health-focused programs. The school nurse may teach programs about basic nutrition, dental care, activity and play, drug and alcohol abuse, domestic violence, child abuse, and issues related to sexuality and pregnancy.

**250.** Health Promotion Models (Pender) have the following assumptions:

1. individuals want to cure disease.
2. individuals want to get better through others acting for them.
3. individuals hope for improvement in self-care without a lot of effort.
4. individuals seek to actively regulate their own behavior.

(4) Assumptions of the Health Promotion Model are: Persons seek to create conditions of living through which they can express their unique human health potential; persons have the capacity for reflective self-awareness, including assessment of their own competencies; persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability; individuals seek to actively regulate their own behavior; individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time; health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their life spans; self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.

**251.** The nurse's role in health promotion is:

1. health teaching and counseling.
2. care of the physical illness.
3. care of the older adult in nursing homes.
4. change the person's behavior.

(1) Individuals and communities who seek to increase their responsibility for personal health and self-care require health education. The trend toward health promotion has created the opportunity for nurses to strengthen the profession's influence on health promotion, disseminate information that promotes an educated public, and assist individuals and communities to change long-standing health behaviors. A variety of programs can be used for the promotion of health, including information dissemination, health risk appraisal and wellness assessment, lifestyle and behavior change, and environmental control programs.

**252.** Bob Glass, age 52, has hypertension and is 40 pounds overweight. As a part of Mr. Glass's treatment, the physician prescribes a weight reduction program. Which history question best assesses the effect of health promotion and protection patterns on Mr. Glass's nutritional status?

1. "Have you had any significant weight gain or loss?"
2. "Do you eat alone or with others?"
3. "Are you content with your present weight?"
4. "Where and how is your food prepared?"

(4) All of these questions help assess nutritional status. However, questions about health beliefs, exercise and activity, nutrition, stress and coping, and socioeconomic patterns can best assess health promotion and protection patterns.

**253.** The California Health Project research showed:

1. that the family influences health.
2. that a couple's type of marital relationship can affect family health status.
3. that children are the primary influence on family health.
4. that the husband has the most influence on the health of the family.

(2) A couple's type of marital relationship can affect family health status according to a well-documented study, the California Health Project (1995). These researchers found that husbands and wives from "balanced" and "traditional" families reported higher health scores than marital partners from "disconnected" and "emotionally strained" families.

**254.** Studies on families and health promotion revealed that family factors provided explanations for a causal relationship between family and illness. The family factors are:

1. marital relationship, parenthood, and family's social support system.
2. family's social support system, health promotion, and risk reduction.
3. health promotion, health hazards, and lifestyle issues.
4. parenthood, childrearing, and lifestyle issues.

(1) These studies found that three family factors provided explanations for a causal relationship between family and illness: marital relationship, parenthood, and the family's social support system.

**255.** There are six stages of health/illness and family interactions. The summary showed:

1. presentation of a sequencing of a family's experience with illness/disability.
2. presentation of health promotion and disease prevention.
3. presentation of family health and symptoms of the individuals.
4. presentation of social disorganization and health promotion.

(1) The six stages of health/illness and family interactions are Stage 1, Family Efforts at Health Promotion; Stage 2, Family Appraisal of Symptoms; Stage 3, Care Seeking; Stage 4, Referral and Obtaining Care; Stage 5, Acute Response to Illness by Client and Family; Stage 6, Adaptation to Illness and Recovery. These stages also present a temporal sequencing of a family's experience with illness/disability.

**256.** Assessment of health/illness by the family serves as a basic point of reference of health behaviors. The earlier stage (Stage 2) begins with:

1. health promotion strategies.
2. family health appraisal status.
3. family's beliefs of health promotion.
4. family's health behavior on the degrees of concern by the symptomatic individual.

(4) The second stage begins when an individual's symptoms are (1) recognized; (2) interpreted as to their seriousness, possible cause, and importance or meaning; and (3) met with varying degrees of concern by the symptomatic individual and his or her family. The stage consists of the family's beliefs about the symptoms or illness of a family member and how to deal with the illness. Because the family serves as the basic point of reference for assessing health behavior and provides basic definitions of health and illness, it influences the individual's perceptions.

**257.** In North America, the \_\_\_\_\_ is usually the major interpreter of the meaning of a particular symptom, the decision maker on what action should be taken.

1. father
2. child
3. mother
4. support person

(3) In North America and many other regions of the world, the mother is usually the major interpreter of the meaning of particular symptoms, the decision maker on what action should be taken, and the informal healthcaregiver. The central family member (usually the mother) who influences the health appraisal is called in some of the literature the “family health expert.”

**258.** Individual characteristics and experiences of the revised Health Promotion Model has a specific behavior affect on the behavior outcome. What are the major outcomes seeking?

1. risk management
2. health promotion
3. perceived self-efficacy
4. commitment to the family

(2) The core of the revised Health Promotion Model emphasizes the importance of behavior-specific cognitions and affect as the primary motivators of behavior. The six behavior-specific behaviors and affect are considered to be of major motivational significance in encouraging an individual to engage in health-promoting behaviors and have been identified within the model as: perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situationL influences. Behavior-specific cognitions and affect that are hypothesized to be directly related to health-promoting actions include positive perceptions of the anticipated expected outcome, minimal barriers to action, feelings of efficacious, and skilled, positive feelings about the health behaviors, presence of family and peer social support, positive role models, and availability of environmental contexts that are compatible, safe, and interesting.

**259.** The nurse can be involved with health promotion as a significant person in helping the family:

1. become a better family.
2. prevent disease.
3. control their symptoms.
4. modify health-promoting behaviors.

(4) Behavior outcomes can be especially significant for nurses to consider, as they are subject to modification through nursing interventions.

**260.** In conducting a health screening for a 12 month old, the nurse would expect that this child has been immunized against which of the following diseases?

1. measles, polio, pertussis, Hepatitis B
2. diptheria, pertussis, polio, tetanus (DTP)
3. rubella, polio, pertussis, Hepatitis A
4. measles, mumps, rubella, polio

(2) By 12 months of age, the child should have had DTP and polio. MMR is not administered until 12 months.

**261.** As part of a routine health screening, the nurse notes the age-appropriate play of a 2 year old. Which of the following is an example of age-appropriate play for a 2 year old?

1. builds towers with blocks
2. tries to color within the lines
3. says “mine!” when playing with toys
4. tries to jump rope

(3) Toddlers are very possessive and struggling for independence. The other play activities are too advanced for a toddler and more typical of a 4 year old.

**262.** During a routine health screening, the nurse should talk to the parents of a 1 year old about which of the following?

1. the potential hazards for accidents
2. appropriate nutrition now the child has weaned from breastfeeding
3. toilet training
4. how to purchase appropriate shoes now the child is walking

(1) Accidents are the primary source of injury in children and may be life-threatening. Appropriate nutrition should have been discussed during the weaning process, and although the purchase of appropriate shoes is important, it is not life-threatening. One year of age is too early to discuss toilet training.

**263.** The school nurse is conducting health screenings on school children. During the screening, she identifies a child with the behavioral characteristics of attention deficit disorder. Which of the following behaviors is consistent with this disorder?

1. slow speech development
2. overreaction to stimuli from the surroundings
3. inability to carry on a conversation
4. concrete thinking

(2) Children with attention deficit disorder are easily distracted but are able to carry on a conversation. Concrete thinking is more indicative of age, and slow speech development has more to do with other learning disabilities.

**264.** Which of the following developmental milestones for a 6 month old would be screened by the nurse during a routine office visit?

1. standing while holding something
2. rolling over
3. sitting up
4. creeping

(2) Rolling over occurs between 4–6 months of age. Sitting up occurs at 7–8 months, creeping at 9–10 months, and standing about 8–10 months.

**265.** During the health screening of an adolescent, which finding by the nurse will require further teaching?

1. The client started her first menses 2 years ago.
2. The client states she is currently on “the pill.”
3. The client states she recently lost 5 pounds.
4. The client states she is experiencing growing pains.

(2) Given the client is on the pill, she requires further teaching regarding protection against STDs. All of the other findings are not abnormal for an adolescent.

**266.** The mother of a 7 year old asks the nurse how frequently her child should receive eye and dental exams. The nurse’s best response is which of the following?

1. Eye exams should be yearly and dental cleaning every 6 months.
2. Eye exams should be every six months and dental cleaning every year.
3. Eye exams are not needed unless a problem is thought to exist and dental cleaning should occur every year.
4. Eye exams should be yearly and dental exams only if a problem arises.

(1) Eye exams should be yearly and dental cleaning every 6 months.



**267.** Which of the following individuals would require a hearing exam?

1. a 4 year old attending daycare
2. a 15 year old who just attended a concert
3. a 3 year old who has had chronic ear infections
4. a 16 year old who likes to work on cars

(3) Chronic ear infections can lead to hearing loss. Brief exposure to loud music doesn't usually lead to hearing loss.

**268.** The nurse recognizes that which of the following individuals are most at risk for osteoporosis and should undergo a bone density exam?

1. a 65-year-old heavyset black woman who smokes one pack of cigarettes per day
2. a 68-year-old thin, Caucasian woman who drinks a lot of coffee
3. a 65-year-old thin black man who drinks a lot of coffee
4. a 68-year-old heavyset Caucasian man who smokes one pack of cigarettes per day

(2) Thin, Caucasian women of postmenopausal age are most at risk for osteoporosis. Additionally, caffeine leeches calcium.

**269.** A six-month-old baby arrives for a well baby screening. The nurse knows that the weight gain for the infant should be approximately which of the following?

1. The baby's weight should be triple that of birth.
2. The baby's weight should be about that of birth.
3. The baby's weight should be quadruple that of birth.
4. The baby's weight should be about double that of birth.

(4) Infants should gain about 7–8 pounds by the 6-month birthday.

**270.** At birth, neonates receive a newborn screening blood test. The nurse knows that the purpose of the test is which of the following?

1. to identify infants with Down's syndrome
2. to identify infants with PKU
3. to identify infants that may have one of a number of metabolic disorders
4. to identify the father of the infant

(3) States mandate which metabolic disorders are tested for in the newborn screening. PKU is only one of a number of disorders that are tested for in the newborn screening. The test has nothing to do with Down's syndrome or identifying the father of the infant.

**271.** Which of the following health screenings do all infants in the hospital setting undergo?

1. hearing
2. vision
3. dental
4. cardiac

(1) Hearing. All infants receive a hearing test. Only infants that are symptomatic receive a cardiac screening, and there is no dental or vision screening for neonates.

**272.** When conducting a health screening assessment on an adolescent, the nurse knows that the best source of information for assessing developmental level and potential health problems is which of the following?

1. the parent
2. the teacher
3. the coach
4. the adolescent

(4) The adolescent is the best source of information. Although the parent, teacher, and coach may be able to give some information, adolescents are able to give the most accurate information about themselves.

**273.** At which of the following ages should a child be screened for lead levels if he lives in housing built prior to 1960?

1. 6 months
2. 7 years
3. 2 years
4. 5 years

(3) Children who live in homes built prior to 1978 should be screened for lead levels at the ages of 1, 2, and 3 years because these are the years that children put items in their mouth.

**274.** The mother of a toddler is concerned that her child eats very little on some days while on other days appears to have a good appetite. The nurse's best response is which of the following?

1. The child should be referred for a nutritional assessment.
2. The child is going to have behavioral problems.
3. The child is normal.
4. The child may have a serious physical condition.

(3) The child is a normal toddler experiencing physiologic anorexia in which over the course of a week, the intake is sufficient to meet the body's needs. No intervention is required.

**275.** The Denver Developmental Screening Tool is often used for screening children developmentally. Which of the following domains are assessed on the instrument?

1. gross motor, fine motor, language, and personal-social
2. initiative, motivation, language, and personal-social
3. independence, gross motor, language, and fine motor
4. initiative, gross motor, language, and independence

(1) The Denver Developmental Screening Tool assesses gross motor, fine motor, language, and personal-social behavior.

**276.** A parent asks the nurse when her infant should be seen for well baby check ups. The nurse informs the parent that the schedule of visits is which of the following?

1. monthly
2. every 6 months
3. at 1, 2, 4, 6, and 9 months
4. at 3, 6, and 9 months

(3) The recommended schedule of visits is at 1, 2, 4, 6, and 9 months, which also follows the recommended timing of immunizations.

**277.** At what age should an individual with a family history for early cardiovascular disease or hyperlipidemia first be screened for cholesterol levels?

1. 5 years
2. 20 years
3. when symptoms arise
4. 11–14 years

(4) The child should be screened in early adolescence if there is a significant family history for early cardiovascular disease.

**278.** A nurse notes that a toddler is rubbing his eyes and blinking frequently as well as holding objects close. Which of the following is the nurse's best action based on this information?

1. Do nothing; this is normal for toddlerhood.
2. Ask the parent whether the child is fatigued.
3. Refer the child for vision screening.
4. Assess the child's intake of Vitamin A.

(3) The noted symptoms indicate possible vision impairment. The child should be referred for vision screening. These symptoms are not normal for toddlerhood, fatigued children, or children who require more Vitamin A.

**279.** During a routine health screening for lice, the school nurse finds several kindergarten children with lice. Which of the following is important information for her to tell the parents?

1. Bedding and clothing should be washed in hot water.
2. Pesticide should be sprayed in the home.
3. Once cured, the child may share his combs again with others.
4. The child may return to school after the second treatment with medicated shampoo.

(1) Bedding must be washed in hot water. Spraying the home is not recommended with small children. Children should never share their combs with others. Most children may return to school after the first shampoo treatment is completed.

**280.** Blood pressure screening is recommended periodically in women age 18 years and older. The nurse knows this recommendation is which of the following?

1. every 6 months
2. annually
3. at least every 2 years
4. every 5 years

(3) The recommendation is at least every two years.

**281.** When teaching breast self exam to a postmenopausal client, the nurse should recommend that the client do which of the following?

1. The client no longer needs to perform breast self exam.
2. The client should vary when she performs breast self exam so she can determine how her breast changes during the month.
3. The client should perform breast self exam during the same time each month.
4. The client should perform breast self exam whenever she remembers each month.

(3) Postmenopausal women should select a specific day each month to perform breast self exam. Because of breast changes throughout the month, it is important to compare the breast tissue month to month during the same time of the month.

**282.** The nurse knows that client teaching for breast self exam has been effective when the client verbalizes which of the following?

1. "I should perform breast self exam about 1 week after my period."
2. "I should lay on my left side and feel in a circular motion on my breast."
3. "I should expect to see discharge from my nipple when squeezed."
4. "I should recognize that dimpling of the breast is normal."

(1) Breast self exam is to be performed 7–10 days after menses. The client should lay flat on her back to examine her breasts. There should not be any discharge when the nipple is squeezed, and dimpling of the breast is not normal and must be evaluated by a physician.

**283.** The nurse knows that client teaching for testicular self exam has been effective when the 20-year-old client verbalizes which of the following?

1. "I should vary when I perform testicular self exam so I can determine changes during the month."
2. "I should perform testicular self exam during the same time each month."
3. "I should perform testicular self exam whenever I remember each month."
4. "I am too young for testicular cancer and do not need to do testicular self exam."

(2) Testicular self exam is to be performed during the same day each month. Age does not impact the recommendation for regular testicular self exam.

**284.** The nurse knows that client teaching for testicular self exam has been effective when the client verbalizes which of the following?

1. "I need to examine each testicle by gently rolling it between the thumb and fingers of the other hand."
2. "I need to examine each testicle by palpating in a circular motion."
3. "I need to perform the exam after a cool shower."
4. "I need to perform the exam while the penis is erect."

(1) Testicular self exam is performed after a warm bath or shower and involves examining each testicle separately by gently rolling it between the thumb and fingers of the other hand.

**285.** The mother of a 4-year-old asks the nurse when her child should have her first dental check up. The nurse knows that which of the following is most accurate?

1. Children need to see a dentist when they start school.
2. Children need to see a dentist when they experience pain or have a problem with a tooth.
3. Children need to see a dentist after they lose their first tooth.
4. Children need to see a dentist by about age 3.

(4) The recommendation is that children have their first dental appointment by about age 3.

**286.** A mother brings her 14-year-old daughter to the clinic for an annual checkup. The nurse recognizes that important part of the exam will be to screen for which of the following?

1. sexual behavior
2. truancy behavior
3. defiant behavior
4. cleanliness behavior

(1) An important screening during adolescence is to assess sexual behavior. Sexual behavior may be life threatening.

**287.** During an annual health screening, the nurse identifies that an adolescent female has begun to engage in sexual intercourse. The highest priority teaching for this adolescent should be which of the following?

1. contraception
2. emotional issues related to sexuality
3. prevention of STDs
4. early recognition of STD symptoms

(3) The highest priority is to give the adolescent information about the prevention of STDs, given that some STDs may be life threatening.

**288.** Which of the following statements verbalized by an adolescent would the nurse identify as requiring further assessment and possibly referral or intervention?

1. "I sometimes don't feel like wearing a seatbelt in the car."
2. "I ride a motorcycle without a helmet."
3. "I enjoy going to parties."
4. "I'm a master dieter and have great control over my weight; I recently lost 10 pounds!"

(4) Although options 1 and 2 require further education and option 3 may require further assessment, option 4 may indicate anorexic or bulimic behaviors.

**289.** Vaccines are forms of what type of immunity?

1. active
2. passive
3. transplacental
4. active and passive immunity

(1) Vaccines are active immunity. Passive immunity comes from antibodies produced in another human or host. Transplacental immunity comes from passive immunity transferred from mother to infant.

**290.** A 2 year old diagnosed with HIV comes to the clinic for immunizations. Which of the following vaccines would the nurse expect to administer in addition to the scheduled vaccines?

1. pneumococcal vaccine
2. hepatitis A vaccine
3. Lyme disease vaccine
4. typhoid vaccine

(1) Pneumococcal vaccine should be administered as a supplemental vaccine. Hepatitis A vaccine is for travellers and individuals with chronic liver disease. The Lyme disease vaccine is for persons ages 15–70 who are at risk for Lyme disease (transmitted by ticks primarily). The typhoid vaccine is for workers in microbiology laboratories who frequently work with *Salmonella typhi*.

**291.** A 30-year-old male is being seen at a local clinic. He asks the nurse who should receive the Hepatitis A vaccine. Her best response is which of the following?

1. "Children who are 18 months of age."
2. "Infants receive the vaccination at birth."
3. "People who travel to other countries."
4. "Individuals who may come into contact with blood."

(3) Hepatitis A is for individuals who travel or persons with chronic liver disease. Infants receive the Hepatitis B vaccine at birth. Diphtheria, pertussis and tetanus vaccine (DTaP) is administered at 18 months of age. Individuals who come into contact with blood should be immunized against Hepatitis B.

**292.** Which of the following vaccines are not part of the regular schedule of immunizations for children?

1. DTaP
2. MMR (measles, mumps and rubella vaccine)
3. Hib (Haemophilus influenza type B)
4. Pneumococcal

(4) Pneumococcal vaccine is a supplemental vaccine recommended for children who may have conditions such as HIV. DTaP, MMR, and Hib are all regularly scheduled vaccines for children.

**293.** A mother brings her 1-year-old child to the clinic. The child has no record of previous immunizations, and the mother confirms the child has not been immunized. Teaching by the nurse should include which of the following?

1. Immunizations may be started at any age.
2. The recommended immunization schedule must be followed exactly.
3. If a primary series of immunizations is interrupted, the series must be restarted.
4. The child is at increased risk for reaction to the vaccines, after they are started.

(1) Although a recommended immunization schedule exists, immunizations may be started at any age. An interrupted series may be continued and need not be restarted. There is no increased risk for reaction to vaccines due to delay.

**294.** Which of the following vaccines is a live virus?

1. varicella
2. IPV
3. DTP
4. hepatitis B

(1) Varicella is a live virus as is oral poliovirus (OPV). IPV is an inactivated polio vaccine.

**295.** The nurse will be administering the inactivated polio vaccine. For which of the following findings in the chart would she hold the vaccine?

1. pregnancy
2. swelling and tenderness after previous administration
3. hypersensitivity to neomycin
4. fatigue with previous administration

(3) Hypersensitivity to neomycin is a contraindication for administration of the inactivated polio vaccine. Fatigue and swelling/tenderness are common reactions with this vaccine. Pregnancy is not a contraindication.

**296.** The nurse will be administering the Hib vaccine. For which of the following findings in the chart would she hold the vaccine?

1. anaphylaxis after previous administration of the vaccine
2. pain at the injection site after previous administration
3. redness at the injection site after previous administration
4. mild cold symptoms

(1) Anaphylaxis is the only contraindication for administration of this vaccine. Pain and redness at the injection site are common reactions after administration of this vaccine. Mild cold symptoms are not a contraindication.

**297.** At birth, which of the following vaccines can the nurse expect to administer to the neonate?

1. vitamin K
2. erythromycin
3. hepatitis B
4. Hib

(3) Hepatitis B is commonly administered prior to discharge from the hospital. Vitamin K and erythromycin are medications administered to neonates but are not vaccines. Hib is not administered until 2 months of age.

**298.** Which of the following is a common reaction to the Hepatitis B vaccine?

1. joint pain
2. elevated temperature
3. irritability
4. photophobia

(4) A common reaction to the Hepatitis B vaccine is photophobia. Joint pain and elevated temperature are associated with administration of the MMR vaccine. Irritability is a common reaction to the IPV vaccine.

**299.** A 1 year old arrives in the clinic with a rash. The child received an MMR immunization 2 days ago. The nurse's best response to the mothers concerns about the rash is which of the following?

1. The rash is a serious reaction to MMR immunization.
2. The rash is a common reaction to the MMR immunization.
3. The rash indicates an allergy to the MMR immunization.
4. The rash is unrelated to the MMR immunization.

(2) A noncontagious rash is a common reaction to the MMR immunization. Serious reactions include anaphylaxis and seizure disorder.

**300.** Contraindications for administration of the inactivated polio vaccine include which of the following?

1. allergy to streptomycin
2. family member who is immunosuppressed
3. allergy to eggs
4. recently received blood products

(1) An allergy to streptomycin is a contraindication for administration of the inactivated polio vaccine. The live oral polio vaccine cannot be administered if there is a family member who is immunosuppressed. Allergy to eggs is a contraindication for administration of the MMR. The varicella vaccine may not be administered if the individual has recently received blood products.

**301.** OPV is to be administered to a 2-month-old infant. Teaching has been successful when the parent states which of the following?

1. "I must report a temperature greater than 99.6°F to the physician."
2. "I must not get pregnant for 3 months."
3. "I must report any redness at the injection site."
4. "I must wash hands carefully after diaper changes to avoid transmission of the virus."

(4) The live virus can be transmitted via stool to the caregiver if hands are not washed carefully. Low-grade temperature does not require reporting to the physician. This vaccine is oral so there is no injection site. Pregnancy of the mother is not relevant.

**302.** A killed virus vaccine is a vaccine where which of the following is true?

1. It's a toxin that has been treated to weaken its effects but retains its antigen properties.
2. It's a microorganism in weakened form.
3. It's a microorganism that is dead but still capable of inducing the body to produce antibodies.
4. It's an altered organism that is joined with another substance to augment the immune response.

(3) Option 1 is a toxoid vaccine; option 2 is a live virus vaccine; and option 4 is a conjugated form of a vaccine.

**303.** The best way to prevent the spread of communicable disease is by which of the following?

1. emphasizing good hand washing among the public
2. implementation of a comprehensive immunization program
3. mandatory reporting of public health department statistics
4. proper disposal of contaminated substances by healthcare facilities

(2) A comprehensive immunization program is the best way to protect against the spread of communicable diseases.

**304.** A 2-month-old child is being seen at a clinic for a well baby check up. The nurse expects the child will receive the DTP vaccine. It is important for the child to receive the pertussis vaccine early for which of the following reasons?

1. No passive immunity from the mother exists for pertussis.
2. Only passive immunity from the mother exists for pertussis.
3. Only transplacental immunity exists from the mother for pertussis.
4. Some passive immunity (but limited) from the mother exists for pertussis.

(1) For pertussis, no passive immunity exists from the mother.

**305.** A 12 month old is being seen at a clinic for a well baby check up. The nurse expects the child will receive the measles vaccine. This vaccine has not been given prior to 12 months of age due to which of the following reasons?

1. No passive immunity from the mother exists for measles.
2. Passive immunity from the mother exists for measles.
3. Limited active immunity exists from the mother for measles.
4. Active immunity exists from the mother for measles.

(2) Passive immunity exists from the mother during the early period of infancy.

**306.** A 6-month-old child is seen at the local clinic. The nurse can expect to administer the DTP vaccine via which of the following routes?

1. orally
2. subcutaneously
3. intramuscularly
4. intradermally

(3) DTP is given intramuscularly.

**307.** A toxoid vaccine is a vaccine where which of the following is true?

1. It's a toxin that has been treated to weaken its effects but retains its antigen properties.
2. It's a microorganism in weakened form.
3. It's a microorganism that is dead but still capable of inducing the body to produce antibodies.
4. It's an altered organism that is joined with another substance to augment the immune response.

(1) Option 3 is a killed virus vaccine; option 2 is a live virus vaccine; and option 4 is a conjugated form of a vaccine.



**308.** When giving the varicella vaccine to a child less than 13 years of age, the nurse should inform the parents which of the following?

1. The child may still contract a mild case of chicken pox.
2. The child will be completely immune from chicken pox.
3. The child will need subsequent boosters of the vaccine.
4. The child will need the vaccine administered prior to one year of age.

(1) The varicella vaccine decreases the severity of chicken pox and does not protect the child completely from contracting the disease. The vaccine may be administered to children after 1 year of age. Children who are 13 years or older must receive two doses 1 month apart.

**309.** Which of the following vaccines is contraindicated if there is an immunocompromised individual living in the home?

1. diphtheria and pertussis vaccines
2. measles, mumps, and rubella vaccines
3. live poliovirus vaccine
4. hepatitis B vaccine

(3) Administration of the live poliovirus vaccine may infect other individuals in the house, particularly an individual who is immunocompromised. The measles, mumps, and rubella vaccines as well as the varicella vaccine is contraindicated in persons who are immunocompromised but not necessarily if the family members are immunocompromised.

**310.** For which of the following findings would the administration of MMR be contraindicated?

1. mild cold symptoms
2. fever of 100.4°F after previous administration of MMR
3. redness at the injection site after previous administration of MMR
4. allergy to eggs

(4) Administration of MMR is contraindicated if an individual is allergic to eggs. The MMR may be administered even if mild cold symptoms are present. Elevated temperature and redness at the injection site are common side effects of MMR vaccine.

**311.** The priority nursing action for a 12-month-old child who has just received the MMR immunization is which of the following?

1. Administer Tylenol prophylactically.
2. Monitor the child for 15 minutes after the vaccine is given.
3. Educate the mother on the importance of subsequent vaccine administration.
4. Document the immunization in the immunization record.

(2) The child must be monitored for severe reactions such as anaphylaxis for 15 minutes after the vaccine is given. Although the education of the mother and documentation of the immunization are important, the physical response of the child may be life-threatening. Tylenol may be given prophylactically to prevent elevated temperature and for mild pain but these are common side effects and not life-threatening.

**312.** A live virus vaccine is a vaccine where which of the following is true?

1. It's a toxin that has been treated to weaken its effects but retains its antigen properties.
2. It's a microorganism in weakened form.
3. It's a microorganism that is dead but still capable of inducing the body to produce antibodies.
4. It's an altered organism that is joined with another substance to augment the immune response.

(2) Option 3 is a killed virus vaccine; Option 1 is a toxoid vaccine; and option 4 is a conjugated form of a vaccine.

**313.** Federal law requires that the nurse record which of the following when administering vaccines?

1. the lot number and expiration date of the immunization given
2. the address of the pharmacy from where the vaccine was obtained
3. the age of the client to whom the vaccine is administered
4. the name, address, and phone number of the parent who is present during the administration of the vaccine

(1) The lot number, expiration date, month, day, year of administration, manufacturer, vaccine name, site, and route of administration and the name, title, and address of the person who administers the vaccine are required.

**314.** Which of the following is true regarding administration of the smallpox vaccine?

1. Everyone should be immunized against smallpox.
2. It is currently part of the regular immunization schedule.
3. It is considered a live virus.
4. It is not possible to spread the virus to other people once immunized.

(3) The smallpox vaccine is a live virus that is currently *not* part of the regular immunization schedule and not recommended for everyone. Because it is a live virus, it is possible to spread the virus to other people when vaccinated.

**315.** For which of the following would the nurse expect to administer a tetanus vaccine?

1. an 8 year old who just had a sliver removed
2. a 20 year old whose last tetanus vaccine was administered 10 years ago
3. a 1-month-old infant during a well baby check up
4. a 15 year old whose last tetanus vaccine was administered 4 years ago

(2) Tetanus vaccine is administered every 10 years or if an individual has come into contact with a rusty object penetrating the skin. The first tetanus vaccine is administered at 2 months of age.

**316.** The priority nursing action prior to administration of the influenza vaccine to an 80 year old is:

1. assess for prior anaphylactic reaction to the vaccine.
2. obtain informed consent.
3. assess for allergy to eggs.
4. review the package insert.

(1) Prior anaphylactic reaction to the vaccine is a contraindication for administration of the vaccine. Allergy to eggs is not a contraindication. Informed consent should be obtained and review of the package insert is important, but the priority is to assess for previous reactions to the vaccine.

**317.** A conjugated form of vaccine is a vaccine where which of the following is true?

1. It's a toxin that has been treated to weaken its effects but retains its antigen properties.
2. It's a microorganism in weakened form.
3. It's a microorganism that is dead but still capable of inducing the body to produce antibodies.
4. It's an altered organism that is joined with another substance to augment the immune response.

(4) Option 2 is a live virus vaccine; option 3 is a killed virus vaccine; option 1 is a toxoid vaccine.

**318.** The current major concern in the reduction of maternal and infant mortality and morbidity is that:

1. a large segment of the population is not receiving maternity care.
2. families appear unconcerned about quality healthcare.
3. the personnel shortage in the maternity field will increase.
4. maternal-child health workers are not adequately prepared.

(1) There is a deep concern about healthcare for the majority of the world's population, specifically low life expectancies and high mortality and morbidity rates among infants and children, which led to the global health strategy of primary healthcare. The WHO (World Health Organization) declaration emphasizes health or well-being as a fundamental right and a worldwide social goal. It attempted to address inequality in the health status of persons in all countries and to target government responsibility for policies that would promote economic, social, and health development. *Healthy People 2010* has goals of providing easy access of healthcare for the individual; access to quality health services; promoting health and preventing illness, disability, and premature death.

**319.** The nurse in teaching an obese client about nutritional needs and weight loss should include all of the following except:

1. knowledge of food and food products.
2. development of a positive mental attitude.
3. adequate exercise.
4. start a fast weight loss diet.

(4) Many people seeking to lose weight are lured by the promises of "quick fixes." Food fads and wonder diets promising a "new slim you," are promoted daily in hour-long infomercials. Promises about diets that sound too good to be true are rampant. Unhealthy eating habits begin early in life and often continue into adulthood. The working mother and dad coupled with a hectic schedule of activities for youngsters make it difficult for wholesome meals to become part of an everyday routine. The emphasis must shift from the quantity to the quality of food we consume. With proper knowledge of food and food products, the entire health of our population will be improved. In most instances, weight is the result of too much food intake. Other important factors such as improper eating habits, inadequate exercise, and sedentary work and leisure activities, all play critical roles in an individual remaining overweight. Developing a positive mental attitude and a firm commitment to changing bad lifestyle habits are needed to overcome the problem of being overweight. The following list of food items should be greatly reduced in our daily intake: white refined sugar and white refined flour; alcoholic beverages, coffee, and cola drinks; artificially flavored products with many added preservatives; junk foods, candy, and empty-calorie snacks; foods high in saturated fat and fried foods including many fast foods; preprepared convenience type foods that are often low in nutritional value. This list is not all-inclusive, but should serve as a guide for those individuals who are sincerely interested in their health and well-being.

**320.** A client asks the nurse what risk factors increase the chances of getting skin cancer? The risk factors are all except:

1. light or fair complexion.
2. exposure to sun for great periods of time.
3. certain diet and foods.
4. history of bad sunburns.

(3) Conditions that increase risks for skin cancer are: light or fair complexion; history of having bad sunburns or scars from previous burns; personal or family history of skin cancer; frequently work or play outdoors with exposure to the sun; exposure to x-rays or radiation; exposure to certain chemicals through work or hobby (coal, pitch, asphalt, petroleum); repeated trauma or injury to an areas resulting in scars; older than age 50; male gender; live in geographic location near the equator or at high altitudes. Ways to prevent skin cancer are: avoid exposure to the sun; wear a hat to protect the face; avoid all sun lamps; if exposure to the sun is unavoidable, use a sunscreen with a minimum of 15 sun protection factor (SPF). Teach your patient how to recognize a potential problem, to inspect skin frequently; note all birthmarks, freckles, and moles; and seek medical assistance if any of the following are noted: change in color, change in shape, change in surface texture, change in size, change in the surrounding skin, a new mole, or a sore that does not heal.

**321.** To improve overall health, the nurse would place highest priority on assisting the client to make lifestyle changes for which of the following habits?

1. drinking a six-pack of beer each day
2. eating an occasional chocolate bar
3. exercising twice a week
4. using relaxation exercises to deal with stress

(1) Health promotion is motivated by the desire to increase people's well-being and health potential. The nurse promotes health by maximizing the patient's own strengths. Identification and analysis of the patient's strengths are a component of preventing illness, restoring health, and facilitating coping with disability or death. The nurse facilitates decisions about lifestyle that enhance one's quality of life and encourage acceptance of responsibility for one's own health.

**322.** A nurse who is assessing the health-related physical fitness of a client as part of a health assessment would focus on which of the following aspects of the assessment?

1. agility
2. speed
3. body composition
4. power

(3) A health assessment should focus on possible risk factors of the client. A risk factor is something that increases a person's chance for illness or injury. A health-risk appraisal is an assessment of the total person, including focusing on lifestyle and health behaviors.

**323.** A nurse is trying to motivate a client toward more effective management of a therapeutic regimen. Which of the following actions by the nurse is most likely to be effective in increasing the client's motivation?

1. Determine whether the client has any family or friends living nearby.
2. Develop a lengthy discharge plan and review it carefully with the client.
3. Teach the client about the disorder at the client's level of understanding.
4. Make a referral to an area agency for client follow-up.

(3) Nursing functions include interventions to promote adaptation to illness and evaluations of interventions as supportive or therapeutic. Supportive interventions help maintain the present health state and prevent further illness. Therapeutic interventions promote healing and restore health.

**324.** Appropriate nursing interventions for a client experiencing illness using a wellness model would include:

1. providing holistic care as appropriate.
2. discovering the causative agent of the disease.
3. ascertaining the client's perception of seriousness of the disease.
4. providing care directed solely to treat the disease.

(1) Holistic healthcare is healthcare that takes into account the whole person interacting in the environment. The concern of nursing is with man in his entirety, his wholeness. Nursing's body of scientific knowledge seeks to describe, explain, and predict about human beings.

**325.** When completing a health risk appraisal, the nurse should assess all of the following except:

1. personal health history.
2. family health history.
3. use of medications and drugs.
4. type of health insurance.

(4) A health risk appraisal should be a complete examination, including the risk factors for altered health. The role of the nurse in reducing risk factors involves activities that promote health.

**326.** Nursing's code of ethics requires nurses to provide holistic care for all clients. This is an example of which of the following stages of Kohlberg and Gilligan's moral development?

1. social contract, utilitarian
2. universal ethical principle
3. law and order
4. instrumental relativist

(2) Ethical theories are systems of thought that attempt to explain how we ought to live and why (action-guiding theories). Action-guiding theories fall into two main categories: utilitarian, the rightness or wrongness of an action depends on the consequences of the action, and deontologic, which is an action that is right or wrong independent of its consequences. A professional code of ethics provides a framework for making ethical decisions and sets forth professional expectations.

**327.** Which of the following statements should guide developing a program to teach adolescents how to inject insulin?

1. Adolescents may help gain a sense of role identity by working with other diabetic teens.
2. Adolescents will not be concerned about peer opinion.
3. Adolescents are concerned with achieving independence from peers and parents.
4. Adolescents are not able to understand the consequences of noncompliance.

(1) Adolescence is a time of rapid physical change, reproductive maturity, and emotional development. It is a time of making initial career choices, establishing personal relationships, and selecting personal values and lifestyles.

**328.** Because of marginal placental previa, Jane is instructed to report immediately any vaginal bleeding, no matter how slight. There is a possibility that the birth will have to be by cesarean section. Jane cries and wonders aloud why she just cannot be normal, like any other pregnant woman. She states she feels so out of control. The best intervention for Jane is one based on the concept that:

1. this is a normal feeling for all pregnant mothers, and Jane will just have to work through it psychologically.
2. because of her age, Jane's fears are heightened and related to the fact that she may not have another chance to have a baby.
3. Jane is exaggerating her situation and creating her own anxiety.
4. Jane's career and lifestyle have elements of personal control in them to which she has become accustomed; feeling out of control is distressing for her.

(4) Anxiety/fear related to the complication of pregnancy is a great reason for loss of control. The nurse should support, teach, or provide other health-promotion activities.

**329.** The family is the most important in the emotional development of the individual because it:

1. provides support for the young.
2. gives rewards and punishment.
3. helps one to learn identity and roles.
4. reflects the mores of a larger society.

(3) Socialization, values, and role definition are learned within the family and help develop a sense of self. When established in the family, the child can more easily move into society. Option 1 is true but not as important as identity and roles in relation to emotional development; options 2 and 4 are only a small aspect of the family's influence.

**330.** The nurse must address the healthcare needs of the client. All of the following are health needs except:

1. support and promotion of physiologic and anatomical equilibrium—psychosocial.
2. an environment that is safe and conducive to effective therapeutic care.
3. legal care/development of society.
4. education—health promotion to prevent, minimize, or correct actual or potential health problems.

(3) This classification reflects nonhealthcare needs of the client. Meeting the need in option 1 includes reducing risks that interfere with physiologic or anatomic integrity, promoting comfort and mobility, and providing basic care to assist, modify, or limit physiologic and anatomic adaptation. For option 2, the nurse must provide quality, goal-directed care that is coordinated, safe, and effective. Fulfilling the need expressed in option 4 involves supporting optimal growth and development to provide for the achievement of the highest levels of functioning. This includes encouraging use of support systems and self-care directed toward promoting the prevention, recognition, and treatment of disease throughout the life cycle.

**331.** The nurse in health promotion education includes:

1. supporting and promoting the highest levels of functioning for the individual.
2. limiting responses to crisis.
3. coordinated factors involved with environmental care.
4. emphasizing the illness/disease problems.

(1) This classification reflects those healthcare needs of the client that must be addressed by the nurse.

**332.** Childhood immunizations are given because:

1. they counteract the presence of maternal antibodies.
2. they counteract the impaired immune system.
3. they induce immunity to disease.
4. they prevent allergic reactions.

(3) Immunizations are a process of rendering a person immune or resistant to particular antigenic agents or bacteria.

**333.** A condyloma has been identified during a yearly gynecological examination. While awaiting the biopsy report prior to its removal, the client indicates to the nurse that she is fearful of cervical cancer. The best response by the nurse would be:

1. "Worrying today is not going to help the situation."
2. "It is very upsetting to have to wait for a biopsy report."
3. "Of course you don't have cancer; a condyloma is always benign."
4. "No operation is done without specimens being sent to the laboratory first."

(2) This recognizes the client's feelings of anxiety are valid. Option 1 does not recognize the client's concerns and may inhibit the expression of feelings; option 3 is false reassurance. Although a condyloma is a benign wart, the papilloma virus that causes it can bring about neoplastic changes in the cervical tissue, which if not interrupted leads to cervical carcinoma; option 4 is not true and does not recognize the client's concerns.

**334.** A characteristic of infants and young children who have experienced maternal deprivation is:

1. extreme activity.
2. proneness to illness.
3. responsiveness to stimuli.
4. tendency toward overeating.

(2) Infants who have experienced maternal deprivation usually exhibit failure to thrive (for example, weight below third percentile, developmental retardation, clinical signs of deprivation, and malnutrition). These physical and emotional

factors predispose the infant to a variety of illnesses. Infants who have experienced maternal deprivation are usually quiet and nonresponsive. Responsiveness to stimuli is limited or nonexistent. Weight below the third percentile is characteristic.

**335.** When teaching a mother how to prevent accidents while caring for her 6-month-old child, the nurse should emphasize that at this age child can usually:

1. sit up.
2. roll over.
3. crawl lengthy distances.
4. stand while holding onto furniture.

(2) Muscular coordination and perception are developed enough at 6 months so the infant can roll over. If unaware of this ability of the infant, the mother could leave the child unattended for a moment to reach for something, and the child could roll off the crib. Sitting up unsupported is accomplished by most children at 7 to 8 months. Crawling takes place at about 9 months of age. Standing by holding onto furniture is accomplished by most children between 8 and 10 months.

**336.** In terms of preventive teaching for the parents of a 1-year-old child, the nurse would speak to them about:

1. accidents.
2. toilet training.
3. adequate nutrition.
4. sexual development.

(1) Because of the infant's increasing mobility, high level of oral activity, and relative lack of fear or appreciation for danger, accidents are the primary cause of death in children above 1 year of age. This is too early for discussions about toilet training. Option 3 is best discussed with the mother prenatally or soon after delivery. This is too early for discussions of psychosexual development.

**337.** A client suspects that she is pregnant, but because she is the only wage earner in her family, she is ambivalent about continuing the pregnancy. The nurse recognizes that the client is in crisis and also remembers that pregnancy and birth are called crises because:

1. there are mood changes during pregnancy.
2. they are periods of change and adjustment to change.
3. there are hormonal and physiologic changes in the mother.
4. narcissism in the mother affects the husband-wife relationship.

(2) Normal periods of marked change and adjustment are called developmental crises and predispose the woman to a situational crisis. Periods of change are transient; they are similar to previous mood changes and should not affect the mother's ability to cope. Hormonal and physiologic changes occur throughout the life cycle of a mature woman and should not now be classified as a crisis. Narcissism becomes a crisis only if the husband withdraws support.

**338.** When a mother with a 3-month-old infant comes to the well-baby clinic, the nurse should include in the accident prevention teaching plan the need to:

1. remove all tiny objects from the floor.
2. cover electric outlets with safety plugs.
3. keep crib rails up to the highest position.
4. remove poisonous substances from low areas.

(3) By 4 months of age, infants are able to turn over and can easily fall from an inadequately guarded height. Although infants are capable of putting small things in their mouths, they are not yet able to crawl and would probably not be placed on the floor. At 4 months of age infants are not yet able to explore the environment to the point that electric outlets pose a problem. Infants are still too small and have not yet developed motor capabilities to get into containers of poison.

**339.** Wellness strategies to be successful usually require(s):

1. improvements in the lifestyle of the entire family.
2. the children to be alert to eating fast foods that are carb smart.
3. the family to continue with their current practices.
4. the family to have other relatives tell them what to do.

(1) Many forms of health promotion, prevention, and risk reductions involve lifestyle issues. All of these issues, to a great degree, require family decisions and participation. Health promotion begins in the family. Wellness strategies, to be successful, usually require improvements in the lifestyle of an entire family.

**340.** Assessment areas for the nurse in working with the family on health promotion strategies would include:

1. the television shows that they watch.
2. the family and all the relatives' statuses.
3. the perceived health status and illness patterns of the family.
4. the mental health status of family and friends.

(3) In addition to looking at the family's overall perceived health status, assessments should include illness patterns of the family members and the family's health practices. The major areas of health practices are: family dietary practices; family sleep and rest practices; family exercise and recreational practices; family therapeutic and recreational drug, alcohol, and tobacco practices; family self-care practices; environmental and hygiene practices; medically based preventive practices; and alternative therapies.

**341.** Dietary practices are very important to the health of the family. The nurse needs to assess this lifestyle because:

1. the nurse wants to change the eating patterns of the family.
2. the nurse knows that being overweight is a major health hazard.
3. the nurse wants to stop all the mainstream weight-loss diets.
4. the nurse has to find out what people are eating.

(2) Poor dietary practices leading to obesity is a primary example of the results of an unhealthy lifestyle. Many Americans are overweight and gain weight as they grow older. About 55 percent of American adults are overweight, with men more likely to be overweight than women. Being overweight is linked to high blood pressure, heart disease, certain types of cancer, arthritis, breathing problems, and other illnesses. Cardiovascular disease is now recognized as a disease of childhood, as obesity increases in young children.

**342.** Which of the following is not a healthcare practice a nurse should encourage?

1. alcohol consumption only in the evening
2. use of certain contraceptions that the nurse feels are good
3. sleeping 8–10 hours per day
4. good hygiene practices

(1) Alcohol consumption is not a healthcare practice, that the nurse should not encourage.

**343.** Teenagers in improving their lifestyles should:

1. get parental permission to participate in sex.
2. consider family planning as a health benefit.
3. continue their lifestyle to match their peers.
4. make only the changes in lifestyle they want to do.

(2) Teenagers need to receive medical care, effective sex and family planning health educational programs. Implement health programs in schools, religious institutions, and health agencies. Such services should be focused not on the



general premise that family planning is an end in itself, but on the health benefits of family planning to the individual and to the growth and development of the family.

**344.** The major reason(s) for the reduction in family planning initiatives is/are:

1. religious and sociopolitical factors.
2. reliability and medical factors.
3. funding and very little teen participation.
4. parents don't want teens to have family planning facilities.

(1) Inconsistent patterns of contraceptive use are attributed to inaccessibility of services, and the fractious debate about the fold of government in providing such services. Religious and sociopolitical factors have interceded to reduce women's and couple's reproductive rights. As of the early 1990s, due to pro-life opposition, the struggle to keep present services available is of growing concern. Public funding for family planning initiatives, as well as abortion, has been cut, and services gravely curtailed for women who are poor and young.

**345.** Types of family nursing diagnoses that are often found in the area of the family's healthcare function include all except:

1. the nurse should be a role model of healthy behaviors.
2. the nursing diagnosis that leads to health promotion.
3. the deficits that lead to stimulus control of the family and other relatives.
4. the educational strategies to assist families to obtain a healthier lifestyle.

(3) Types of family nursing diagnoses that are often found in the area of the family's healthcare function include those that lead to health-promotional or educational strategies, because knowledge deficits of family members are commonly observed. Nurses and other healthcare professionals can assist families to attain a healthier lifestyle by modeling such behaviors themselves. Specific lifestyle modification strategies have been suggested as possible nursing interventions to support families to increase their health-promoting activities and attain their family health goals. Specific strategies that nurses may apply in initiating family lifestyle changes include self-confrontation, cognitive restructuring, modeling, operant conditioning, and stimulus control.

**346.** In 2000, teenage pregnancy and abortion rates are:

1. about the same as in 1990.
2. decreased significantly.
3. are still high.
4. increased significantly.

(3) Teenage pregnancy and abortion rates have been declining in the 1990s, but are still very high. Abortion rates were down nearly a third between 1990 and 1997 among teenagers 15–19 years of age, with teenage birth rates falling 17 percent from 1990 through 1999.

**347.** The skull of a 10-month-old baby should have which of the following?

1. closure of the posterior fontanel
2. closure of anterior fontanel
3. overlap of cranial bones
4. ossification of the sutures

(1) At birth, the anterior fontanel is 4–5 cm in diameter and closes by 24 months; the posterior fontanel closes by age 2 months.

**348.** Which is the best way to position a client's neck for palpation of the thyroid?

1. flexed toward side being examined
2. hyperextended directly backward
3. flexed away from side being examined
4. flexed directly forward

(1) To best position a client's neck for palpation of the thyroid is flexed toward the side being examined. Use gentle touch to palpate the thyroid; it is done with the nurse behind the client. In the technique of the thyroid palpation, the client should flex the neck slightly forward and toward the side being examined to relax the sternocleidomastoid muscle. The thyroid gland, if felt, should feel smooth and soft, and the gland should move freely during swallowing. The right side is frequently slightly larger than the left side.

**349.** The gag reflex test assesses which cranial nerves?

1. IX and X
2. V and VII
3. IX and XII
4. V and X

(1) Gagging during the gag reflex test indicates that cranial nerves IX and X (the glossopharyngeal and vagus nerves) are in tact.

**350.** How many temporary teeth should the nurse expect to find in a client's mouth who is age 5?

1. up to 10
2. up to 15
3. up to 20
4. up to 32

(3) A child may have up to 20 temporary (deciduous or baby) teeth. The first tooth usually erupts by age 6 months; the last by age 30 months. All temporary teeth usually are shed between age 6 and 13 years.

**351.** Mr. Lee comes to clinic with thick green drainage under his eyelids. You are the examiner who is taking his history and will perform a physical examination. You decide to begin with an eye history. General information you should seek is:

1. type of employment.
2. burning or itchy sensation in eyes.
3. position of eyelids.
4. existence of floaters.

(1) Data belonging in a general health history of the eye should include: employment, activities, allergies, medications, lenses, and protective device used. Exposure to irritants and activity risks should be delineated. Routine care of eyes and eye devices should be explored.

**352.** If Ms. Barrett's distance vision is 20/30, which of the following statements is true?

1. The client can read from 20 feet what a person with normal vision can read at 30 feet.
2. The client can read from 30 feet what a person with normal vision can read at 20 feet.
3. The client can read the entire chart from 30 feet.
4. The client can read the chart from 20 feet with the left eye and from 30 feet with the right eye.

(1) The numerator, which is always 20, is the distance in feet between the chart and the client. The denominator, which ranges from 10–200, indicates from what distance a normal eye can read the chart. The eye chart that the nurse uses is the Snellen Eye chart, which assesses distance vision.

**353.** Joe Haynie, age 45, is having difficulty hearing with his left ear. To assess the problem, the nurse performs various hearing tests. Which test evaluates air and bone conduction?

1. whispered voice test
2. watch tick test
3. Weber's test
4. Rinne test

(4) The Rinne test compares air conduction and bone conduction in both ears. This test uses a tuning fork to compare air conduction (AC) to bone conduction (BC). The AC route through the ear canal is a more sensitive route. The tone heard in front of the ear should last twice as long as the tone heard when the fork was on the mastoid process (AC > BC) (2:1). This is a normal, or positive, response. The test is repeated with the other ear.

**354.** During the otoscopic examination, how should the nurse hold Mr. Larkin's ear?

1. Pull the helix up and back.
2. Pull the lobule down and forward.
3. Pull the lobule down and back.
4. Pull the helix up and forward.

(1) To straighten the ear canal of an adult, the nurse should grasp the helix (the prominent outer rim) of the auricle between the thumb and index finger and pull it up and back.

**355.** To inspect the lateral borders of the tongue, you should:

1. pull gauze-wrapped tongue to each side.
2. move tongue side to side with gloved finger.
3. ask client to extend tongue side to side.
4. insert tongue blade obliquely against tongue.

(1) To inspect the lateral surfaces of the tongue for lesions, pull the tongue to either side by grasping the tongue with a 4 × 4 inch gauze pad. Check for any lesions or abnormalities.

**356.** Tactile fremitus is best felt:

1. parasternally at second intercostals space.
2. posterolaterally beneath scapulae.
3. along costal margin and xiphoid process.
4. in suprasternal notch along each clavicle.

(1) Palpate tactile fremitus at bifurcation of bronchii by using palmar surfaces of fingers. Vocal fremitus (tactile) is a vibration resulting from speech or other verbalizations. The fremitus should be felt bilaterally equal. Decreased or absent fremitus occurs when the vibrations are blocked.

**357.** Mr. Joel, age 70, is admitted to the critical care unit with uncontrolled hypertension. As part of the complete cardiovascular assessment, the nurse palpates Mr. Joel's point of maximum impulse (PMI) at the apex. What is the normal size of the left ventricular impulse?

1. less than 1 cm
2. about 2 cm
3. 3 to 4 cm
4. more than 4 cm

(2) At the PMI, light palpation normally reveals a tap with each heartbeat over a space that is roughly ¼-inch (2 cm) in diameter. The PMI is the palpation of the apical impulse. A nurse should feel a tapping sensation occurring in an area that is 1 to 2 cm in diameter and confined to one intercostals space.

**358.** The nurse continues the cardiovascular assessment by auscultating Mr. Brown's heart sounds. Which of the following actions produces the first heart sound (S<sub>1</sub>)?

1. opening of the mitral and tricuspid valves
2. closing of the mitral and tricuspid valves
3. opening of the aortic and pulmonic valves
4. closing of the aortic and pulmonic valves

(2) Mitral and tricuspid valve closing produces S<sub>1</sub> marking the beginning of systole or ventricular contraction.

**359.** The nurse may perform which other test to locate the inferior border of the liver?

1. fluid wave test
2. rebound test
3. obturator test
4. scratch test

(4) If locating the inferior border of the liver through percussion is difficult, the nurse may try the scratch test. The "scratching" on the abdomen or the percussing upward over the tympanic area until dull percussion tone indicates the liver border. The lower border is usually at the costal margin or slightly below it.

**360.** Which inspection of the breasts finding may be abnormal?

1. bilateral nipple inversion
2. nipples that point outward, slightly upward, and lateral
3. bilateral nipple eversion
4. unilateral nipple inversion

(4) Nipples normally point outward, slightly upward, and lateral and may be everted or inverted. One inverted nipple (unless present for a long period of time) should arouse suspicion.

**361.** Joan Davis, age 25, comes to the clinic for her annual gynecologic examination. During the health history, the nurse learns that Ms. Davis uses oral contraceptives. Which factor increases the risk of cardiovascular disease in women using oral contraceptives?

1. smoking
2. barbiturate use
3. phenothiazine use
4. high-protein diet

(1) Smoking increases the risk of cardiovascular disease and thrombi in women using oral contraceptives. Health promotion and teaching by the nurse should be planned for this client.

**362.** Bob Christian, 55, is admitted to the hospital for treatment of benign prostatic hypertrophy. This disorder commonly produces which sign or symptom?

1. urination pattern changes
2. large scrotal mass
3. blood-tinged semen
4. low back pain

(1) Benign prostatic hypertrophy may cause changes in urination pattern, such as hesitancy, incontinence with dribbling, reduced caliber and forced urine stream, and urine retention. This condition is an asymptomatic enlargement of the prostate gland that usually affects older men.

**363.** To perform the Romberg test, the nurse should give the client which instructions?

1. "With your feet together and arms at your sides, try to hold your balance with your eyes open. Now do it with them close."
2. "First, walk on your heels across the room. Now walk on your toes to come back."
3. "Use the thumb of one hand to touch each finger on that hand. Now do the same thing on the other hand."
4. "Lie flat on your back. Now slide your heel down the shin of the opposite leg, moving slowly from the knee to the ankle."

(1) In the Romberg test, the nurse has the client stand with feet together, arms at sides, and without support. Then the nurse observes the client's ability to maintain balance with both eyes open and with them closed.

**364.** Betsy Akin, 72, has osteoporosis. Which factor might have predisposed her to this musculoskeletal disorder?

1. large stature
2. inadequate calcium intake
3. late menopause
4. vigorous exercise

(2) Predisposing factors for osteoporosis include inadequate intake of calcium and Vitamin D, decreased estrogen levels, and small stature.

**365.** Where should the nurse palpate to assess the posterior cervical lymph nodes?

1. along the anterior surface of the trapezius muscle
2. along the anterior surface of the sternocleidomastoid muscle
3. along the posterior surface of the scalene muscle
4. along the posterior surface of the omohyoid muscle

(1) The nurse may palpate the deep posterior cervical nodes along the anterior surface of the trapezius muscle. If the nodes are enlarged and tender, check the structures they drain, for the source of the problem. This could mean a pathological condition.

**366.** While Jane Stevens, 51, is recovering from a thyroidectomy, the nurse periodically assesses for signs and symptoms of hypoparathyroidism, which may result from injury to the parathyroid gland during thyroid surgery. Which assessment finding suggests this endocrine disorder?

1. cold insensitivity
2. confusion
3. polydipsia
4. polyuria

(2) Hypoparathyroidism may produce lethargy, irritability, emotional lability, impaired memory, and confusion.

**367.** The nurse and the physician assess Mr. Phillips. How do nursing models differ from medical models?

1. Nursing models emphasize the human response to illness.
2. Nursing models emphasize the cure of disorders.
3. Nursing models focus on disease diagnosis and treatment.
4. Nursing models focus on high-quality client care.

(1) Both models focus on high-quality care. However, nursing models tend to emphasize the human response to illness; medical models tend to emphasize the cure of diseases.

**368.** What does the nurse do during the assessment step of the nursing process?

1. collects data
2. identifies nursing diagnoses
3. plans care
4. establishes outcome criteria

(1) Assessment of the nursing process is the collection of relevant data from various sources. Assessment refers to the collection of subjective data (obtained from the client and family using the interviewing techniques) and objective data (obtained through physical assessment techniques and diagnostic studies). It provides a basis of identifying problems and serves as a baseline against which to compare further assessments. The nurse should record the data systematically.

**369.** Which of the following data is subjective?

1. vital signs
2. ECG patterns
3. serum enzyme levels
4. Mr. Jones's description of chest pain

(4) Subjective data, referred to as signs and symptoms, obtained from the client and the family using the interviewing technique. They usually are recorded as direct quotations reflecting the client's and families' opinions or feelings about the situation.

**370.** The nurse examines Mr. Smith's past medical records. Which type of data does the nurse obtain from such records?

1. primary source
2. historical
3. secondary source
4. subjective source

(3) Secondary sources of data in past medical records can include family, friends, co-workers, and community groups input; health history and physical assessment reports; and data members of the healthcare team.

**371.** Andrea Smith, 40, returns from the recovery room after a cholecystectomy. Her vital signs are stable, but the nurse feels that "something is just not right." Which problem-solving method is the nurse using?

1. reflexive
2. trial-and-error
3. intuitive
4. scientific

(3) The intuitive method of problem-solving is based on insight related to appreciative thinking—an increased perception about a client, the client's values or beliefs, or a situation. This method has the nurse using insight into the client's characteristics and emotions or conditions to solve a problem. The nurse has an idea about the client that can come from previous experiences and basic scientific literature, using the nursing process.

**372.** Ms. Smith's postoperative assessment includes auscultation of breath and bowels sounds. Which type of data does the nurse obtain with these techniques?

1. subjective
2. objective
3. secondary source
4. medical

(2) Physical assessment techniques and diagnostic studies provide objective data, which reflect findings without interpretation. This data is obtained through physical assessment techniques and diagnostic data.

**373.** When taking a history, you should:

1. use a chronologic and sequential framework.
2. start with the patient's previous records, if available.
3. let patients present data according to their personalities.
4. use a holistic and eclectic structure.

(1) Conduct appropriate introduction, giving own name and role. Ask questions, using a chronologic and sequential framework. Collect data on where, when, what, how, and why factors of present problem. Verify client understanding of circumstances and treatment.

**374.** A patient complains of headache. During the history, he describes his use of alcohol and illicit drugs. These data would most likely belong in the:

1. past medical history.
2. personal and social history.
3. chief complaint.
4. review of systems.

(3) Chief complaint is the brief description of perceived problem. The present problem is the chronologic course of events and state of health. Past medical history is data on childhood and adult illnesses, immunizations, surgeries, serious injuries, medications, allergies, and transfusions. Family history included pedigree diagram of diseases and family illnesses and death. Personal and social history includes socioeconomic and cultural data. Review of systems is organ system review with detailed information depending on the patient's problem. Physiologic and psychologic data are organized according to body systems.

**375.** You observe one of your peers conduct a history and physical examination. The patient states that she wants a small mole she's had since birth removed from her left breast. The patient's present problem relates to insomnia. Your care-giver peer does not examine the breast mole. You are asked to critique the history and physical. Your most helpful response would be that your peer:

1. noted the patient's verbal statements.
2. asked appropriate questions throughout the examination.
3. needed to examine the mole.
4. used focused attention toward the insomnia problem.

(3) Recognize factors that facilitate or impede the process of inspection. Compare the purpose of palpation with its appropriate technique. Compare the purpose of percussion with its appropriate technique. Compare the purpose of auscultation with its appropriate technique. Identify appropriate equipment and associated techniques for measuring vital signs. Identify appropriate equipment and associated techniques for measuring height and weight.





# Psychosocial Integrity

This chapter contains questions and answers from the following topic areas:

- Abuse or Neglect
- Behavioral Interventions
- Chemical Dependency
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End-of-Life Concepts
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Psychopathology
- Religious or Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment
- Unexpected Body Image Changes

*Scenario:* Questions 1–4. Andrew, a college student, usually gets As but scored a C on a difficult examination. When he received the grade, he experienced feelings of nausea and clamminess and had difficulty comprehending what was written on the examination. When his friend tapped him on the shoulder, Andrew jumped, looked dazed, and walked away.

1. What assessment can be made? Andrew is experiencing:

1. panic.
2. mild to moderate anxiety.
3. severe anxiety.
4. reaction formation.

(3) The symptoms described are those of severe anxiety. Andrew seems to have a poor grasp of what is happening in the environment but is not totally disorganized as he would be in panic-level anxiety. His symptoms, however, are more severe than would be found in mild to moderate anxiety. Reaction formation is a defense mechanism unrelated to what is described in the situation.

**2.** To assess the circumstances surrounding Andrew's increase in anxiety, the operational definition of anxiety will explain Andrew's situation as follows:

1. Andrew's expectation of a high grade was unmet, precipitating a threat to his self-esteem and causing anxiety. Rationalization and withdrawal are used as relief behaviors.
2. Andrew was fearful that his friend would learn his grade. The fight response was sublimated, and Andrew consciously chose to use the flight response to avoid his friend.
3. Andrew was acutely angry because he received a low grade and used conversion to cope with the anger.
4. Andrew's physical symptoms and cognitive impairment cannot be explained according to the operational definition of anxiety.

(1) The operational definition of anxiety presents an expectation or need that is unmet, causing anxiety and prompting relief behavior that is later rationalized.

**3.** Andrew runs to the college health service. He is disorganized and only partially coherent. In which room should the nurse place Andrew until he can be seen by the physician?

1. a small empty storage room that has no windows or furniture
2. an interview room furnished with a desk and chairs
3. an examining room containing an examining table, instrument storage cabinets, and a desk
4. the nurse's office furnished with desk, chairs, files, and bookcases

(2) Individuals experiencing panic-level anxiety require a safe environment that is quiet, unstimulating, structured, and simple. Option 2 provides simplicity, few objects with which he could harm himself, and a small floor space in which he can move about. Option 1 would be jail-like and might enhance his anxiety. Options 2 and 3 may be overstimulating and unsafe.

**4.** In order to reduce Andrew's level of anxiety as quickly as possible, the nurse should:

1. stay with him.
2. tell him that help will come.
3. question Andrew to discover the events that led to his decompensation.
4. tell him he will not be allowed to hurt anyone.

(1) The presence of a caring person provides a link with reality. The nurse can offer structure and set limits when necessary. Option 2 implies that the nurse cannot provide assistance. Option 3 is inappropriate when a client is highly disorganized. Option 4 is a premature attempt to set physical limits.

*Scenario:* Questions 5–7. Ashley Martin, a 19 year old, accompanied her boyfriend, Chris, to the emergency room (ER). They had been in a motorcycle accident. Chris was badly hurt, but apparently Ashley was not injured. However, she appeared confused and had trouble focusing on what was going on around her. She complained of dizziness and nausea, although physically she was unharmed. She was hyperventilating as the nurse was doing the assessment.

**5.** The nurse should assess Ashley's level of anxiety as:

1. mild.
2. moderate.
3. severe.
4. panic.

(3) The person whose anxiety is assessed as severe is unable to solve problems and has a poor grasp of what's happening in the environment. Somatic symptoms such as those described by Ashley are usually present. The individual with mild anxiety is only mildly uncomfortable and may even find performance enhanced. The individual with moderate anxiety grasps less information about the situation and has some difficulty problem solving. The individual in panic will demonstrate markedly disturbed behavior and might lose touch with reality.

**6.** What interpersonal relief behavior was Ashley using?

1. acting out
2. somatizing
3. withdrawal
4. problem solving

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

**7.** What statement indicates that the nurse is reacting to Ashley's relief behavior rather than her needs?

1. "It must have been a frightening experience to be in an accident."
2. "Accidents can result in all kinds of feelings. It must have been scary."
3. "I'll stay with you in case you would like to share your feelings with me."
4. "There is nothing physically wrong with you. You need to stop breathing so rapidly."

(4) In option 4 the nurse is addressing Ashley's hyperventilation and other somatic symptoms, rather than Ashley's feelings about the accident. All other options address Ashley's feelings about the accident.

*Scenario:* Questions 8–13. Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board.

**8.** When the nurse who was not promoted first read the memo and learned that the other nurse had received the promotion, she left the room in tears. This behavior is an example of:

1. conversion.
2. regression.
3. introjection.
4. rationalization.

(2) Crying is a regressive behavior. The ego returned to an earlier, comforting, and less mature way of behaving in the face of disappointment. Conversion involves the transformation of anxiety into a physical symptom. Introjection involves intense unconscious identification with another person. Rationalization involves the unconscious process of developing acceptable explanations to justify unacceptable ideas, actions, or feelings.

**9.** The nurse then went to the utility room and slammed several cupboard doors while looking for Kleenex. This behavior exemplifies:

1. displacement.
2. sublimation.
3. conversion.
4. reaction formation.

(1) Displacement unconsciously transfers emotions associated with a person, object, or situation to another less threatening person, object, or situation. She slammed doors instead of striking the other nurse or the administrator who made the promotion decision. Sublimation is the unconscious process of substituting constructive activity for unacceptable impulses. This option cannot be considered correct because the slamming of the cupboard doors cannot be considered a constructive activity. Conversion involves unconsciously transforming anxiety into a physical symptom. Reaction formation keeps unacceptable feelings or behaviors out of awareness by using the opposite feeling or behavior.

- 10.** An aide comes into the utility room and remarks, “You seem pretty angry.” The nurse replies that she isn’t the least bit angry. In this instance the nurse is probably utilizing:
1. reaction formation.
  2. repression.
  3. compensation.
  4. denial.

(4) Denial involves an unconscious process of escaping an unpleasant reality by ignoring its existence; in this case the nurse is unable to acknowledge her true feelings. Reaction formation is an unconscious process that would call for her to display a feeling that is the opposite of anger. Repression would operate unconsciously to exclude the event from awareness. Compensation requires unconsciously making up for perceived deficits by excelling in another area in order to maintain self-esteem.

- 11.** The nurse who was not promoted tells a friend, “Oh, well, I really didn’t want the job anyway.” This is an example of:
1. rationalization.
  2. denial.
  3. projection.
  4. compensation.

(1) This is called the “sour grapes” form of rationalization. Rationalization is an unconscious form of self-deception in which we make excuses. Denial is an unconscious process that would call for her to ignore the existence of the situation. Projection operates unconsciously and would result in blaming behavior. Compensation would result in the nurse unconsciously attempting to make up for a perceived weakness by emphasizing a strong point.

- 12.** The nurse who was not promoted tells another friend, “I knew I’d never get the job. The hospital administrator hates me.” If she actually believes this of the administrator, who, in reality, knows little of her, she is demonstrating:
1. compensation.
  2. reaction formation.
  3. projection.
  4. denial.

(3) Projection results in unconsciously adopting blaming behavior. It allows us to attribute our own unacceptable attributes to other people. Compensation would result in the nurse unconsciously attempting to emphasize a strong point in an attempt to make up for a perceived weakness. Reaction formation would require the nurse to unconsciously adopt behavior that is opposite her actual feelings. Denial involves unconsciously determining to ignore the existence of an unpleasant reality.

- 13.** If, when the nurse who was not promoted met the newly promoted nurse in the hall, she suddenly found she had lost her voice and was unable to offer her congratulations, she would probably be demonstrating:
1. denial.
  2. conversion.
  3. suppression.
  4. repression.

(3) Conversion unconsciously transforms anxiety into a physical symptom that has no organic basis. The symptom resolves a conflict. In this case, if one cannot speak, one cannot be expected to offer congratulations. Denial would involve unconsciously determining to ignore the existence of an unpleasant reality. Suppression consciously puts an event, idea, or feeling out of awareness. Repression unconsciously puts an event, idea, or feeling out of awareness.

**14.** A rather unattractive woman repeatedly tells her husband that although she is not beautiful, she is smart. This is an example of:

1. repression.
2. compensation.
3. identification.
4. denial.

(2) Compensation is an unconscious process that allows us to make up for deficits in one area by excelling in another area to raise self-esteem. Repression unconsciously puts an idea, event, or feeling out of awareness. Identification is an unconscious mechanism calling for the imitation of mannerisms or behaviors of another. Denial calls for escaping an unpleasant reality by ignoring it.

**15.** Which of the following nursing approaches would be most therapeutic in assisting a client to cope with stressful life events?

1. Encourage the client to complain about the stresses experienced.
2. Help the client to refocus only on the positive aspects of stress.
3. Avoid thinking about potential future life changes.
4. Develop the ability and patience to deal with life changes.

(4) It takes both ability and patience to adjust to life changes. The greater one's coping skills, the more effectively one can deal with life stresses. Options 1, 2, and 3 are incorrect; the client needs to look at both positive and negative aspects of change and also to anticipate potential future changes.

**16.** Among the various strategies a client might use to cope with stress and anxiety are which of the following?

1. ventilation of feelings, problem solving, exercise
2. support system, problem solving, striving for independence and retribution
3. family intervening into client's problems and solving them for their significant others
4. role play all feelings and emotions, independence from stressors

(1) Coping strategies for stress reduction include seeking a supportive person, striving for self-discipline/perseverance and expressing feelings, problem solving, doing physical activities and exercise, doing activities that induce relaxation.

**17.** A nurse is teaching a stress-management program for client. Which of the following beliefs will the nurse advocate as a method of coping with stressful life events?

1. Avoidance of stress is an important goal for living.
2. Control over one's response to stress is possible.
3. Most people have no control over their level of stress.
4. Significant others are important to provide care and concern.

(2) When learning to manage stress, it is helpful to believe that one has the ability to control one's response to stress. It is impossible to avoid stress, which is a normal experience. Stress can be positive and growth enhancing as well as harmful. The belief that one has some control can minimize the stress response.

**18.** A client becomes angry and belligerent toward the nurse after speaking on the phone with his mother. The nurse recognizes this as what coping mechanism?

1. compensation
2. introjection
3. displacement
4. projection

(3) Displacement is a coping mechanism in which a person transfers his feelings for one person toward another person who is less threatening.

**19.** What significant event occurs in the orientation phase of a nurse-client relationship?

1. establishment of roles
2. identification of transference phenomenon
3. placement of the client within the client's family structure
4. client agreement that the nurse has the authority in the relationship

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

**20.** At what point in the nurse-client relationship should termination first be addressed?

1. in the working phase
2. in the termination phase
3. in the orientation phase
4. when the client initially brings up the topic

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

**21.** What is the reason for a contract between nurse and client?

1. Contracts state the roles the participants will take.
2. Contracts are indicative of the feeling tone established between participants.
3. Contracts are binding and prevent either party from ending the relationship prematurely.
4. Contracts spell out the participation and responsibilities of both parties.

(4) A contract emphasizes that the nurse works with the client, rather than doing something for the client. Working with suggests that each part is expected to participate and share responsibility for outcomes. Contracts do not, however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.

**22.** The nurse can best communicate to the client that he/she has been listening by:

1. restating the main feeling or thought the client has expressed.
2. making a judgment about the client's problem.
3. offering a leading question such as, "And then what happened?"
4. saying, "I understand what you're saying."

(1) Restating allows the client to validate the nurse's understanding of what has been communicated. It's an active listening technique. Regarding option 2, judgments should be suspended in a nurse-client relationship; leading questions ask for more information rather than showing understanding; in option 4, you state you understand, but the client has no way of measuring your understanding.

**23.** After the client discusses her relationship with her father, the nurse says, “Tell me if I am understanding your relationship with your father. You feel dominated and controlled by him?” This is an example of:

1. verbalizing the implied.
2. seeking consensual validation.
3. encouraging evaluation.
4. suggesting collaboration.

(2) Consensual validation is a technique used to check one’s understanding of what the client has said. Consensual validation is the process by which people come to agreement about the meaning and significance of specific symbols. Through this experience, individuals develop the ability to related effectively.

**24.** The best definition of communication is:

1. the sending and receiving of messages.
2. the effect of sending verbal messages.
3. an on-going interactive form of transmitting transactions.
4. the use of message variables to send information.

(3) Communication is a personal, interactive system—a series of ever-changing, on-going transactions in the environment. Transmissions are simultaneously received (decoded), sent (encoded), and influenced by the total of experiences and perceptions of the receivers and senders. Through communication and interaction with others, an individual develops a sense of identity and being. Communication is the basis of a person’s self-concept and the relationship of this self to another individual, to a group of people, and to the world.

**25.** You say to your client who is five years old, “Why don’t you stop crying?” This is an example of which type of nontherapeutic technique?

1. requesting an explanation
2. probing
3. challenging
4. testing

(1) The nurse asks “why” of the client, thereby asking for a reason for feelings and behaviors when the client may not know the reason. Communication interventions are an integral part of the nursing process. The nurse should use appropriate communication techniques that are appropriate for the individual, particularly noting (assessing) age and maturational stage.

**26.** You say to your adult client, “I have 30 minutes available to talk with you at 10 AM today.” This is an example of which therapeutic communication technique?

1. offering self
2. presenting reality
3. focusing
4. testing

(1) Offering self: The nurse must be able to tolerate, respect, and redirect the anxiety that accompanies the recognition of possible failure. Nurses provide the client with the opportunity for an honest and authentic relationship. The care dimension in such a relationship promotes human growth through recognition of the uniqueness of the individual, recognition of the resources within the individual, and provision of an empathetic atmosphere conducive to the client’s self-exploration. The focus of caring supports the individual’s healing resources. Three categories of nurse behaviors indicate caring: giving of self, meeting client’s needs in a timely manner, and providing comfort measures for clients and family members.

**27.** The nurse says to the client, “I noticed the anger in your voice when you speak of your mother. Tell me about that.” What communication techniques is the nursing using?

1. giving information and encouraging evaluation
2. presenting reality and encouraging formulation of a plan
3. making observations and exploring
4. reflecting and suggesting collaboration

(3) Making observations calls for the nurse to state an observed behavior, and exploring calls for the nurse to ask the client to elaborate.

**28.** Which statement about nonverbal communication is correct?

1. It is easy for a nurse to judge the meaning of a client’s facial expression.
2. The nurse’s verbal messages should be reinforced by nonverbal cues.
3. The physical appearance of the nurse rarely influences nurse-client interaction.
4. Words convey meanings that are usually more significant than nonverbal communication.

(2) Message variables are selective verbal and nonverbal stimuli from the internal and external environment that give shape, direction, and focus to the message.

**29.** A student nurse is caring for a 75-year-old client who is very confused. The student’s communication tools should include:

1. written directions for bathing.
2. speaking very loudly.
3. gentle touch while guiding ADLs (activities of daily living).
4. flat facial expression.

(3) Nonverbal, gentle touch is an important tool here. Providing appropriate forms of touch to reinforce caring feelings. Because tactile contacts vary considerably among individuals, families, and cultures, the nurse must be sensitive to the differences in attitudes and practices of clients and self.

**30.** The nurse who develops the skill of attentive listening understands that the skill requires:

1. absorbing both the content and the feeling the person is conveying without selectivity.
2. assuming what needs the client has.
3. adopting a closed professional posture.
4. total relaxation by the listening nurse.

(1) Attentive listening is listening actively, using all the senses, as opposed to listening passively with just the ear. It is probably the most important technique in nursing and is basic to all other techniques. Attentive listening conveys an attitude of caring and interest without selection or bias. This encourages the client to talk.

**31.** Mary is a client on the acute care unit. The nurse notices as she talks with Mary that Mary is unable to make and maintain eye contact. She puts her head down and looks at the floor. The nurse’s assessment of Mary is:

1. nonverbal communication.
2. mental status.
3. nursing diagnosis.
4. social skill.

(1) Eye contact and body movement are considered nonverbal communication. The nurse considers nonverbal communication in relation to the client’s culture. Attention must be paid to facial expression, gestures, and eye contact.



**32.** A patient reports to her therapy group that she has begun to practice a conscious relaxation technique. She's pleased with its effectiveness in reducing her need to wash her hands. One member responds by saying that conscious relaxation is a bunch of nonsense. A nurse is serving as group leader. Which of the following interventions would be the best one for the nurse to make at this point?

1. Smile and change the subject.
2. Ask the group member why he thinks the technique worked so well for the patient.
3. Foster group cohesiveness by asking the member to keep negative opinions to himself.
4. Ask the member to share his understanding of and experience with conscious relaxation.

(4) This response seeks first to clarify the group member's experience and then to provide an opportunity for the group leader or another member to explain the purpose of conscious relaxation. Option 1 ignores the issue being discussed. Option 2 takes the focus away from the patient's concern. Option 3 does not foster group cohesiveness; negative opinions are valid and should not be suppressed.

**33.** A school-aged client has just been diagnosed with juvenile diabetes. The client is very angry about her new disease. Which of the following statements is most appropriate for the nurse counselor working with this client?

1. "Try not to be angry because you are receiving the best care possible."
2. "It is all right to be angry with your friends, but try not to be angry with your parents."
3. "Tell me what you do when you get angry."
4. "You learn quickly and will probably handle the treatment very well."

(3) In therapeutic communication, the nurse chooses the best words to say and uses nonverbal behaviors that are consistent with these words. If a client is angry and upset, the nurse should begin with assessing the meaning of the patient's communication. First listen to the client's verbal and nonverbal messages and interpret their meanings. The nurse should not be defensive or argumentative to the anger as this would block communication. The next step is deciding the desired client outcome. The nurse should focus on the client's feelings rather than the accusations and reflect that she understood the client's feelings.

**34.** Which of the following actions would negate the principle of genuineness of the nurse?

1. The nurse smiles at a joke the patient has told.
2. The nurse shows unconditional positive regard.
3. The nurse's behavior is inconsistent with her words.
4. The nurse self-discloses.

(3) Genuineness and sincerity are demonstrated by consistency in words and actions. The process involves the nurse receiving information from the client with open, nonjudgmental acceptance and communicating the understanding of the experience and feelings so that the client feels understood.

**35.** When a nurse is assigned to care for a client who speaks another language, an important intervention to facilitate communication with the client would be:

1. relying on gestures and other forms of nonverbal communication.
2. using validation as a therapeutic tool.
3. using an interpreter.
4. using simple pictures.

(3) When a client speaks another language, an interpreter will help facilitate communication. Option 1, nonverbal communication, is important; however, the client also needs to be able to verbalize thoughts and feelings to the nurse. Option 2, validating, is an important therapeutic technique when relating to persons of a different culture. However, the technique requires verbal communication. Option 4, pictures, can aid in communication of the basic needs; however, they do not facilitate communication in other areas.

**36.** A nurse and client are talking comfortably about the client's progress and feelings about the therapeutic relationship. This is typical of which phase in the therapeutic relationship?

1. assessment
2. orientation
3. working
4. termination

(4) Termination is an important phase in the therapeutic relationship, during which the nurse and client reassess the client's progress, evaluate goal attainment, and explore how the therapeutic relationship was experienced. It is also important to deal with feelings about termination during this phase. Option 1, assessment, would be an ongoing part of the therapeutic relationship and would occur in all phases. The phases of the relationship in options 2 and 3 are characterized by establishing trust (orientation) and planning outcomes/interventions to assist the client to meet goals (working).

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

1. denial
2. anger
3. bargaining
4. acceptance

(1) When in denial (Kübler-Ross's Stages of Grieving), the patient refuses to believe that loss is happening and is unready to deal with practical problems.

**38.** The nurse is caring for a client who is dying of terminal cancer. While assessing the client for signs of impending death, the nurse should observe the client for:

1. elevated blood pressure.
2. Cheyne-Stokes respiration.
3. elevated pulse rate.
4. decreased temperature.

(2) Cheyne-Stokes respirations are rhythmic waxing and waning of respirations from very deep breathing to very shallow breathing with periods of temporary apnea, often associated with cardiac failure. This can be a premonitory sign (clinical sign) of impending or approaching death.

**39.** In the United States, several definitions of death are currently being used. The definition that uses apnea testing and papillary responses to light is termed:

1. whole-brain death.
2. heart-lung death.
3. circulatory death.
4. higher brain death.

(1) To declare whole-brain death most protocols require two separate clinical examinations, including induction of painful stimuli, papillary responses to light, oculovestibular testing, and apnea testing. Options 2 and 4 have no specific test required. Option 3 is not a current definition of death in the United States.

**40.** The nurse is caring for a dying client who has persistently requested that the nurse “help her to die and be in peace.” According to the Code for Nurses, the nurse should:

1. ask the client whether she has signed the advance directives document.
2. tell the client that the nurse will ask another nurse to care for the client.
3. instruct the client that only a physician can legally assist a suicide.
4. try to make the client as comfortable as possible but refuse to assist in death.

(4) One of the competencies necessary for nurses to have in giving high-quality care to clients/families during the end of life care is: apply legal and ethical principles in the analysis of complex issues and end-of-life care, recognizing the influence of personal values, profession codes, and patient preferences.

**41.** The nurse in supporting a family, when a death is sudden and unexpected, needs to know:

1. that survivors of an unexpected death have greater emotional turmoil and shock than those of expected death.
2. that survivors of an unexpected death have less emotional turmoil and shock than those of expected death.
3. that survivors of an unexpected death have the same emotional turmoil and shock as those of expected death.
4. that survivors of an unexpected death have little emotional turmoil and shock because they were not there.

(1) Sudden death produces greater emotional turmoil and shock in survivors than does a gradual, expected death. Survivors do not have time to engage in anticipatory grief. The most disturbing and unbalancing feature of sudden death is its unexpectedness.

**42.** A mother has just given birth to a baby who has just died. The mother has been crying extensively and states, “I can’t believe this has happened to me. . . I did everything right during this pregnancy.” How should the nurse respond to this mother?

1. Tell her she did nothing wrong; it was God’s will.
2. Tell her she can have another baby.
3. Tell her that her behavior is not going to solve anything.
4. Tell her nothing and let her mourn this loss in the manner for her.

(4) Perinatal loss is a great tragedy for the parents. A bereaved mother must resolve the crisis of perinatal loss in addition to the crisis of pregnancy. Such a loss is described as losing part of one’s self, loss of self-worth. The perinatal grief response must involve attachment and detachment as a part of the mourning process.

**43.** Which of the following is the primary concern of the nurse for providing care to a dying client? The nurse should:

1. attempt to assess hope in the client and to be a source of encouragement to the client.
2. intervene in the client’s activities of daily living and promote as near-normal functions as possible.
3. allow the client to be alone and expect isolation on the part of the dying person.
4. promote dignity and self-esteem in as many interventions as possible.

(4) Nursing interventions of the dying client should promote dignity and self-esteem. Dying clients often feel they have lost control over their lives and over life itself. Helping clients die with dignity involves maintaining their humanity, consistent with their values, beliefs, and culture.

**44.** Which of the following is true concerning hospice nursing care?

1. It is designed to meet the client's individual wishes, as much as possible.
2. It usually aims at offering curative treatment for the dying client.
3. It involves learning how to provide postmortem care.
4. It offers quality care to clients with good third-party payment plans.

(1) Hospice provides an alternative treatment plan for the adult or pediatric client with a life-limiting medical problem. Hospice care focuses on support and care of the dying person and family with the goal of facilitating a peaceful and dignified death.

**45.** Which of the following is true regarding a patient with a Do Not Resuscitate (DNR) order?

1. The patient will no longer make decisions regarding their own healthcare.
2. The patient and family recognize that the patient will most likely die within the next 48 hours.
3. The nurse should continue all treatments for the patient focusing on comfort, support, and medical management.
4. A DNR order, once written, is valid throughout the life of the patient and applies to all hospital admissions.

(3) A DNR order controls CPR (resuscitation procedures) and similar life-saving treatments. All other care continues. Competent patients can still make decisions regarding their own healthcare. No time designation is put in a DNR order. A new DNR is required for each admission to a healthcare facility, as medical conditions and patient's view may change.

**46.** The nurse in the urgent care clinic observes several family members behaving in a stunned manner after the physician has informed the family that their 16-month-old child is dead. The physician suspects that the child died of sudden infant death syndrome (SIDS). The nurse should:

1. ask the family to make funeral arrangements.
2. determine whether the family is willing to make an organ donation.
3. urge the family members to return home.
4. provide a quiet place for the family to grieve.

(4) The nurse should provide a quiet place for the family to grieve. Along with this support, nurse should also attempt to provide an atmosphere for open communication. The nurse can educate and answer questions of the family with a calm and patient demeanor.

**47.** The nurse has informed the family of a terminally ill comatose client about the loss of various senses during imminent death. The nurse determines that the family understands the instructions when one of the family members says that it is believed that the last sense to leave the body is the sense of:

1. taste.
2. touch.
3. smell.
4. hearing.

(4) The clinical signs of impending or approaching death include inability to swallow, pitting edema, decreased gastrointestinal and urinary tract activity, bowel and bladder incontinence, cold clammy skin, cyanosis, Cheyne-Stokes respirations, loss of reflexes and senses, and lastly, hearing.

**48.** At which age does a child begin to accept that he or she will someday die?

1. less than 5 years old
2. 5–9 years old
3. 9–12 years old
4. 12–18 years old

(3) Until children are about 5 years old, they believe that death is reversible. Between ages 5–9, the child knows death is irreversible but believes it can be avoided. Between 9–12 years of age, the child recognizes that he, too, will someday die. At ages 12–15, the child builds on previous beliefs and may fear death, but often pretends not to care about it.

**49.** An autopsy is an examination of the organs and tissues of a human body after death. Ultimate consent for an autopsy can be obtained from:

1. family.
2. patient.
3. physician.
4. coroner.

(4) The coroner may decide that an autopsy is advisable and can order that one be performed even though the patient (previous to death) or family of the patient has refused consent.

**50.** Which statement would be evaluated as indicating successful mourning has taken place?

1. “She was so strong after her husband died. She never cried the whole time. She kept a stiff upper lip.”
2. “She was a wreck when her sister died. She cried and cried. It took her about a year before she resumed her usual activities with any zest.”
3. “You know, S. still talks about his mother as if she were alive today. . .and she’s been dead for 4 years.”
4. “He never talked about his wife after she died. He just picked up and went on life’s way.”

(2) Successful mourning consists of a task-based model that attempts to describe tasks that are involved in the process of mourning: Accept the reality of the loss; share in the process of working through the pain of grief; adjust to an environment in which the deceased is missing; restructure the family’s relationship with the deceased and reinvest in other relationships and life pursuits.

**51.** K., 34, is single and has very few close friends and relatives. He was very dependent upon his mother before her death, although he often complained about her intrusiveness. What statement best describes his risk for problems in resolving his grief?

1. He is at no particular risk since the death of parents is an expected event in one’s life.
2. He is at low risk, since the task of young adulthood is to develop independence from the family of origin.
3. He is at moderate risk.
4. He is at high risk because he was dependent on his mother, demonstrated ambivalence toward her, and has a limited support system.

(4) Acute grief can be a time of exacerbation of a pre-existing medical or psychiatric problems. A history of depression, substance abuse, or post-traumatic stress disorder can complicate grief and may need special treatment.

**52.** Which statement about palliative care could serve as a basis for the introduction a nurse gives to a client?

1. Palliation focuses on aggressive comfort care when cure is no longer the goal.
2. Clients receiving palliative care can realistically expect discomfort at life’s end.
3. Palliation addresses emotional and spiritual pain more than physical pain.
4. Clients receiving palliative care are relieved of the responsibility of most care decisions.

(1) Palliative care is a medical specialty that has grown out of the hospice movement and the increasing national awareness of the need for better care for the dying. It focuses on aggressive comfort care when the goal is no longer cure.

**53.** Which nursing strategy will be disruptive to the provision of nursing care for terminally ill clients?

1. seeing a dichotomy between the living and the dying
2. understanding that there is no “right” way to die
3. learning to follow the client’s lead
4. maintaining one’s emotional health

(1) The nurse needs to understand as much as possible about end-of-life issues so she/he can help to protect these individuals and give support where necessary. Palliative care by the nurse focuses on aggressive comfort care (Holistic care) when the goal is no longer a cure.

**54.** According to Engel, three phases are involved in the grieving process. By experiencing these phases, a person is believed to:

1. die with dignity.
2. develop self-awareness.
3. accept the inevitable.
4. help family members.

(2) The phases of grieving have significance for the individual in working through the loss. If the stages are gone through, and the individual works through them in a positive way, the outcome of the person will begin to resume more usual activities, feel better, and place loss in perspective.

**55.** The primary belief of psychiatric mental health nursing is that:

1. most people have the potential to change and grow.
2. every person is worthy of dignity and respect.
3. human needs are individualistic to each person.
4. some behaviors have no meaning and cannot be understood.

(2) Every person is worth dignity and respect. Every person has the potential to change and grow. All people have basic human needs in common with others. All behavior has meaning and can be understood from the person’s perspective.

**56.** James returns home from school mad and upset as he did not get to speak to the teacher about his grade. After returning home, he kicks the dog. This coping mechanism is known as:

1. denial.
2. suppression.
3. displacement.
4. fantasy.

(3) Displacement is the transference of anger at the school teacher (because he could not speak to the teacher about his grades). Anger is vented or displaced on the dog as a convenient object.

**57.** Which of the following coping mechanisms protects an individual from anxiety?

1. denial and fantasy
2. rationalization and suppression
3. regression and displacement
4. reaction formation and projection

(1) Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety.

**58.** Milieu therapy is best employed to do which of the following?

1. Investigate the patient's view of the world.
2. Promote socialization skills.
3. Focus on inappropriate behavior.
4. Provide repetitive ordinary experiences on a daily basis.

(4) Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.

**59.** The "token economy" is a type of therapy that focuses on:

1. play therapy.
2. behavior modification.
3. milieu therapy.
4. physical changes.

(2) Behavior modification gives positive feedback and rewards for appropriate behavior. Behavior modification requires negative behavior if its not destructive or life threatening.

**60.** How does the American Nurses' Association (ANA) define the psychiatric nursing role?

1. a specialized area of nursing practice that employs theories of human behavior as its "science" and the powerful use of self as its "art"
2. a specialized area of nursing practice that assists the therapist to relieve the symptoms of the patient
3. a specialized area of nursing practice that involves solving the patient's problems and giving him the answers
4. a specialized area of nursing practice in which the patient is committed to long-term therapy with the nurse

(1) The ANA sets standards of practice on psychiatric and mental health nursing roles: the quality of care, performance appraisal, education, ethics, collaboration, and research through the use of the nursing process.

**61.** The general adaptation syndrome is based on the concept of stressor and response to stressors over time. This theory was developed by:

1. Freud.
2. Sullivan.
3. Selye.
4. Dixs.

(3) Hans Selye published his research concerning the physiologic response of a biological system to stress or change imposed upon it.

**62.** Maladaptation is said to be present when the person's responses are:

1. directed at stabilizing internal biological processes.
2. directed toward the preserving of self-esteem.
3. aimed at maintaining the individual's integrity.
4. aimed at disrupting the individual's integrity.

(4) Maladaption is viewed as negative or unhealthy. It disrupts the integrity of a person.

**63.** In the General Adaptive Syndrome (GAS) phases, which one is thought to cause illnesses?

1. alarm stage
2. resistance stage
3. exhaustion stage
4. recuperative stage

(3) Exhaustion stage occurs when the patient's adaptive energy is depleted and the patient has no other resources for adaptation: disease of adaptation of HA, CAD, ulcers, colitis, and mental disorders.

**64.** The way a person perceives and responds to stress is *most* affected by which of these predisposing factors?

1. age
2. gender
3. past experiences
4. family history

(3) Past experiences result in learned patterns that can influence an individual's adaptive responses.

**65.** Coping strategies are considered maladaptive when the conflict being experienced:

1. gets resolved.
2. intensifies.
3. increases energy sources.
4. maintains vital signs in normal parameters.

(2) Coping strategies are maladaptive when conflict being experienced goes unresolved or intensifies. Energy sources are depleted. This increases vulnerability to physical and psychological illnesses.

**66.** In taking a thorough history, the nurse questions the patient about past family illnesses. This is an attempt to evaluate which of the predisposing factors of adaptation or maladaptation?

1. genetic influences
2. past experiences
3. adverse conditions
4. physical characteristics

(1) Genetic influences are acquired through family structure—family history of physical and psychological conditions (strengths and weaknesses and temperament). This behavior present at birth and evolves with development.

**67.** If an individual's stress response is prolonged over a long time frame, the endocrine system adapts to one of the GAS stages, which results in which one of the following?

1. decreased blood pressure
2. increased libido
3. decreased resistance to disease
4. increased inflammatory response

(3) Prolonged stress leads to the stage of exhaustion in Selye's GAS theory, which predisposes the individual to a disease of adaptation.



**68.** The ANA standards of practice for the nurse who is not Master's or doctorally prepared include:

1. basing actions on theoretical foundations.
2. being accountable to a psychiatrist for patient care.
3. conduction of clinical research.
4. conduction psychotherapy.

(1) The standards clearly state that practice is to be guided by the use of theory. Option 2 is incorrect, because the ANA standards are focused on independent nursing functions. Options 3 and 4 are incorrect because conduction research and doing psychotherapy require a minimum of a Master's degree preparation.

**69.** Based on Maslow's theory, which human need must be met first before the others can be considered?

1. security and safety
2. love and acceptance
3. beauty and philosophy
4. recognition and competence

(1) After food and water, security and safety are necessary before a person can strive to meet higher needs. Physiologic needs take precedence over psychological and spiritual needs. Options 2, 3, and 4 are all higher needs on Maslow's hierarchy.

**70.** As a consistent aspect of the care environment, the staff meets weekly to discuss the diagnoses and treatment protocols of newly admitted patients. Which framework for psychiatric care does this approach represent?

1. biomedical
2. psychodynamic
3. behavioral
4. cognitive

(1) The biomedical framework is based on the disease model. Syndromes are diagnosed, and treatment plans are based on what is currently known about the condition and its treatment. Options 2, 3, and 4 refer to other frameworks for psychiatric practice.

**71.** The coping mechanism that allows a person to get into the car and drive to work without fear of injury or trauma is:

1. repression.
2. regression.
3. projection.
4. denial.

(4) Denial generally operates as a healthy mechanism that protects the person from immediate shock of reality. Repression is the process by which feelings and thoughts are forced into the unconscious. Projection is the displacement of feelings, perceived as negative, onto another individual. Regression is a process by which a person avoids anxiety by returning to an earlier, more comfortable time.

**72.** A daughter, age 2 ½, begins to wet her pants when her newborn sister is brought home from the hospital. This represents which of the following defense coping mechanisms?

1. regression
2. denial
3. repression
4. displacement

(1) Regression is where a person avoids anxiety by returning to an earlier more secure time in life where needs were met more readily. Denial is an avoidance concept. The person is protected from immediate shock of reality. Repression is where certain thoughts and feelings are focused into the unconsciousness. Displacement is the transfer of an emotion from its original object to a substitute object.

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

1. review his/her own cultural beliefs and biases.
2. respectfully request the couple to utilize only medically approved healthcare providers.
3. realize the client will have to learn their new country's accepted medical practices.
4. study family dynamics to understand the male and female gender roles in the client's culture.

(1) The nurse in giving care to this client, must know the cultural beliefs of both the client and themselves. The known biases can bring together better communication and improve the client's outcome. All phases of the nursing process are affected by cultural beliefs.

**74.** Nursing considerations when caring for African American clients include that:

1. families are generally distant and nonsupportive.
2. special personal/cultural norms.
3. fad diets are a cultural norm.
4. clients are generally future-oriented.

(2) The nurse should recognize the African American client may have special symbolic meanings that may be used to maintain, protect, or restore physical, mental, or spiritual health.

**75.** When caring for a Native American family, the nurse needs to consider which of the following?

1. The family solely consists of only the parents and children.
2. Native Americans tend to be future-oriented.
3. Some Native Americans use herbs and psychological treatment of illnesses.
4. Healthcare is usually prescribed by a medicine man (shaman).

(3) Symbols of health or traditions may include certain ritualistic items that are used to maintain, protect, or restore physical, mental, or spiritual health.

**76.** The three universal spiritual needs include all of the following except:

1. meaning and purpose.
2. love and relatedness.
3. forgiveness.
4. God's permission.

(4) Religious teachings (health) help to present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. God is the center of many religions (major), but not all.

**77.** The difference between spirituality and religion is that spirituality is a/an:

1. belief about a higher power.
2. individual's relationship with a higher power.
3. organized worship.
4. belief in invisible energy or ideal.

(2) Religion may be considered a system of beliefs, practices, and ethical values about a divine or super-human power or powers worshipped as the creator(s) and ruler(s) of the universe. Spirituality is a belief or relationship with some higher power, creative force, driving being, or infinite source of energy.

**78.** Spirituality affects a client's life in all of the following areas except:

1. nutritional intake.
2. ability to handle stress.
3. sexual expression.
4. genetic make-up.

(4) Spirituality is a belief or a relationship with some higher power and does not have any bearing on or attribute to genetic make-up.

**79.** Which of the following is an example of a religious belief that is a life-denying experience?

1. sacrament of the sick/Roman Catholic
2. Kosher foods/Jewish
3. restrictions on sterilization/Islam
4. yoga and biofeedback/Middle East

(3) The Islamic prayer, from East Jerusalem, represents prayer as a way of maintaining mental health. This depicts a symbolic example. Traditions and rituals place restrictions on sterilization (practice).

**80.** Data for a spirituality assessment include:

1. general spiritual beliefs.
2. judgment about a client's beliefs.
3. parent's spiritual beliefs.
4. rationale for specific beliefs.

(1) A part of the nursing assessment includes the client's spiritual beliefs, so that goals can be established to have better client outcomes. It is helpful to determine how deeply a given person identifies with their spiritual beliefs (health and illness beliefs).

**81.** An appropriate question to assess a client's specific spiritual needs during a hospital stay is:

1. "Do you have any spiritual or religious concerns that may affect your care?"
2. "What do you want from me to help you with your relationship with God?"
3. "Are you angry with God for letting you get sick?"
4. "What's your faith or religion affiliation?"

(1) It is helpful to determine how deeply a given person identifies with their spiritual beliefs (health and illness beliefs and practices). The assessment then can be used in the nursing care given.

**82.** The client who expresses her spiritual anger to God for allowing her spouse to die is experiencing:

1. spiritual distress: spousal loss, related to anger.
2. spiritual distress: anger, related to spousal loss.
3. dysfunction grieving, related to spousal loss.
4. hopelessness, related to spousal loss.

(2) The spiritual facet includes both positive and negative learned spiritual practices and teachings; dreams, symbols, stories; protecting forces; and metaphysical or native forces. Religious health belief views health and illness as a result of and dependent on God's will.

**83.** Appropriate nursing action for the client goal “develop and maintain positive spiritual practices” includes:

1. noting the client’s request to keep their rosary while in surgery.
2. judging the client’s specific spiritual needs and requests.
3. encouraging the attendance of the pastor at the client’s bedside.
4. client states that he is at peace with his impending death.

(3) When the client needs or requests a religious leader, one should be encouraged to attend the client. Religion (spiritual practices) gives a person a frame of reference and a perspective with which to organize information.

**84.** A successful resolution of the nursing diagnosis “spiritual distress, related to anger over spouse’s death” is if the client:

1. discusses his anger with the nurse.
2. reconciles his anger with his higher power.
3. asks to go to the hospital chapel.
4. tells his daughter he is angry.

(2) For health and wellness, knowledge of the client’s physical, mental, emotional, and spiritual dimensions must be in balance or harmony. A frequent component is some spiritual practice that is a part of the reconciliation of emotional stress; thus harmony and balance can occur.

**85.** Your client’s husband asks you to pray for her. What would be the best initial response for a nurse who personally believes in prayer?

1. “May I call the chaplain to come and pray with you?”
2. “I know your faith is important to you. It is to me, too.”
3. “For what would you like me to pray?”
4. “Isn’t it wonderful that we have a God with whom we can share our concerns?”

(3) Option 3 is best to assess the client’s needs and to provide the nurse with spiritual information to help support both the client and family member. Option 1 might be interpreted as distancing by the client; options 2 and 4 are inappropriate responses.

**86.** The nurse in counseling with clients should know:

1. rituals, customs, practices.
2. customs, dietary, medications.
3. practices such as Voodoo.
4. religion, customs, gender habits.

(1) In providing culturally competent care, the nurse should learn the rituals, customs, and practices of the major cultural groups, so that the nurse can appreciate the richness of diversity and better care for the clients.

**87.** The term “culturally sensitive” implies that the nurse:

1. is prepared to transcultural nursing.
2. possesses knowledge of the traditions of diverse peoples.
3. applies underlying knowledge to providing nursing care.
4. understands the context of the client’s situation.

(2) “Culturally sensitive” implies that the nurse possesses some basic knowledge of and constructive attitudes toward the diverse groups found in the setting in which they are practicing. With option 1, the nurse must have an advanced degree and certification. Options 3 and 4 apply to nursing care in general and are irrelevant to this question.

**88.** An individual's heritage and cultural background can:

1. disrupt the process of nursing care.
2. lead to conflicts between nurse and client.
3. influence health beliefs and practices.
4. influence and modify the client's cultural characteristics.

(3) Health beliefs and practices, family patterns, communication style, space and time orientation, and nutritional patterns may influence the health beliefs and practices of the client as well as the nurse-client relationship.

**89.** In initiating care for a client of a different culture than the nurse, which of the following would be an appropriate statement?

1. "Since in your culture, people don't drink ice water, I will bring you hot tea."
2. "Do you have any books I could read about people of your culture?"
3. "Please let me know if I do anything that is not accepted in your culture."
4. "You will need to set aside your usual customs and practices while you are in the hospital."

(3) The nurse should indicate that he/she is open to diverse views and practices. Option 1 assumes the client follows this particular cultural practice, which may not be the case. Option 2 implies that you need to learn more about culture. Option 4 is an incorrect approach to culturally appropriate care.

**90.** Culture is the:

1. classification of human beings into groups based on particular physical characteristics.
2. condition of belonging to a group whose members share a unique heritage.
3. socially inherited characteristics of a human group.
4. learned behavior by a particular person.

(2) Culture is not physical and not limited to group membership. Additionally, it is not only learned behavior. It is defined as the nonphysical traits, such as values, beliefs, attitudes, and customs. Culture also defines how health is perceived.

**91.** In caring for a patient recovering from cardiovascular accident (CVA) of the middle cerebral artery, the nurse notices that only half of the patient's lunch tray is eaten. The patient may be experiencing which complication of a CVA?

1. ptosis
2. olfactory dysfunction
3. homonymous hemianopia
4. judgment alteration

(3) Homonymous hemianopia is a visual defect involving the temporal half of each visual field, leaving that area as not seen. This results in the sides of the plates of food not eaten, as it cannot be seen by the patient, unless the tray is turned.

**92.** A patient who has suffered a right hemisphere cardiovascular accident (CVA) will be expected to exhibit:

1. nonfluent aphasia.
2. impulsivity, highly distractible.
3. slow and cautious behavior.
4. motor deficit on the right side.

(2) Right hemisphere CVA behaviors include motor deficit on the left side; spatial perceptual loss; denial or unawareness of deficit, overestimates of one's ability; poor judgment; impulsivity; highly distractible and left visual field loss.

**93.** The most sensitive indicator of changes in level or orientation of perception is:

1. pupillary responses.
2. change in level of consciousness.
3. increase in conjugate movement.
4. slurred speech.

(3) Change in locus of control (LOC) is the most sensitive indicator of changes in perception/sensation. This precedes slurred speech or changed pupillary responses.

**94.** Expressive aphasia is associated with:

1. left hemisphere cardiovascular accident (CVA).
2. right hemisphere cardiovascular accident (CVA).
3. occipital area cardiovascular accident (CVA).
4. temporal area cardiovascular accident (CVA).

(1) Expressive, nonfluent aphasia is associated with left hemisphere cardiovascular accident (CVA).

**95.** Which area of the brain is associated with perception?

1. temporal lobe
2. parietal lobe
3. frontal lobe
4. occipital lobe

(2) The right side of the brain, especially the parietal lobe, is important in perception. Temporal lobe makes memories and stores them. Frontal lobe is reasoning, personality, and mathematical. Occipital lobe is for vision.

**96.** Agnosia is a sequelae of cardiovascular accident (CVA). This involves the loss of ability to:

1. recognize and use familiar objects correctly.
2. read and write.
3. carry out a learned sequence.
4. recognize relationships of various body parts.

(1) Agnosia involves the inability to recognize familiar objects.

**97.** A transient ischemia attack is best defined as:

1. neurological deficits resolving within 24 hours.
2. neurological deficits resolving in 72 hours.
3. neurological deficits lasting 7 days.
4. neurological deficits lasting 5 days.

(1) A transient ischemia attack is a neurological deficit that resolves in 24 hours with no sequelae. Deficits that resolve in 72 hours are a reversible ischemic neurological deficit (RIND). Options 3 and 4 are full cardiovascular accident (CVA).

**98.** In teaching a patient with Myasthenia Gravis to take her medication, the nurse will instruct her to take it:

1. at bedtime to help in breathing.
2. 30 minutes prior to eating.
3. 30 minutes after eating.
4. once a day, preferably in the morning.

(2) The best time to take mestinon medication is 30 minutes before meals, so that muscle strength will be improved at the time of eating.

**99.** Parkinson's disease is a chronic, progressive motor disorder caused by the loss of:

1. dopamine from substantia nigra.
2. acetylcholine from the basal ganglia.
3. muscarinic receptors in the muscles.
4. myelination of the motor nerves.

(1) Destruction of the dopaminergic neurons in substantia nigra reduces the amount of neurotransmitter dopamine.

**100.** The four classic manifestations of Parkinson's disease are:

1. tremors, rigidity, bradykinesia, and postural instability.
2. ptosis, salivation, altered gait, and postural instability.
3. sporadic muscle jerkiness, dysphagia, altered gait, and urinary overflow.
4. fatigue, paresthesias, decrease of temperature, and paralysis.

(4) Tremor of Parkinson's disease is known as pill rolling (nonintentional) tremors; muscle movement is slowed and stiff. Rigidity causes the loss of facial expression and forward tilt of the body for posture.

**101.** Myasthenia Gravis is a rare, chronic disease that affects the deficit of which neurotransmitter?

1. dopamine
2. acetylcholine
3. GABA
4. serotonin

(2) Acetylcholine, a neurotransmitter, decreases the number of acetylcholine receptors on the post-synaptic membrane.

**102.** The medication most commonly used in the management of Parkinson's disease is:

1. Mestinon.
2. Sinemet.
3. Allopurinol.
4. Crestor.

(2) The drug of choice in managing Parkinson's disease is Sinemet. This drug is a combination of Carbidopa and Levodopa, which restores dopamine to the brain. Carbidopa blocks peripheral conversion of the Levodopa making more dopamine available in the brain. Levodopa crosses the blood brain barrier and is converted to dopamine.

**103.** Which client is at greatest risk for experiencing sensory overload?

1. a 40-year-old client who has no family and is in isolation
2. a 28-year-old quadriplegic client in a private room
3. a 16-year-old listening to loud music
4. an 80-year-old admitted for emergency surgery

(4) A sudden, unexpected admission for surgery may involve many experiences (for example, lab work, x-rays, and signing of forms) while the client is in pain or some form of discomfort. The time for orientation will thus be lessened. After surgery, the client may be in pain and possibly in a critical care setting. Options 1 and 2 reflect a greater risk for sensory deprivation, and Option 3 is a normal activity for a teenager.

**104.** Which of the following is *not* an appropriate nursing strategy to prevent sensory deprivation in an elderly client?

1. Determine need for glasses and hearing aids.
2. Note feet and condition of dentures.
3. Provide large print books and magazines.
4. Prescribe eye drops to assist in clearing vision.

(4) Sensory deprivation is thought of as a decrease in/or lack of meaningful stimuli. When a person experiences sensory deprivation, the balance in the reticular activating system is disturbed. The person often experiences alterations in perception.

**105.** In assessing a patient's response to direct light directly into the eye, the nurse is assessing which test?

1. visual acuity
2. peripheral vision
3. pupillary response
4. extra ocular movements

(3) Direct light into the patient's eye assesses pupillary response. As the beam is directed through the pupil and on to the retina, stimulation of the third cranial nerve causes the muscles of the iris to constrict. Evaluate pupils bilaterally for size, accommodation, and reaction to light.

**106.** In assessing a patient with Myasthenia Gravis (MG), one of the earliest findings is:

1. lid lag.
2. opaque lenses.
3. decreased pupillary reflex.
4. ectropin.

(1) Muscle weakness is a hallmark of Myasthenia Gravis. Lid lag or ptosis is one of the earliest cues to MG.

**107.** The major neurotransmitter that is responsible for sleep is:

1. GABA.
2. acetylcholine.
3. dopamine.
4. serotonin.

(4) Serotonin is responsible for sleep. Serotonin is thought to decrease the activity of the RAS (reticular activating system), thereby inducing and sustaining sleep.

**108.** Most patients who have a CVA have pathology most frequently associated with the:

1. Circle of Willis.
2. middle cerebral artery.
3. basilar artery.
4. vertibular artery.

(2) Middle cerebral artery (MCA) is the artery coming off the carotid artery. MCA problems are more commonly affected.



**109.** A 17-year-old female was raped by a young man in her neighborhood. She is in the emergency room for evaluation and tests. After the procedure is completed, a rape crisis counselor (nurse specialist) talks to the client in a conference room regarding the rape crisis. Implementing a system of routine counseling by the nurse specialist for the raped victim represents:

1. assessment.
2. anticipatory crisis intervention.
3. empathetic concern.
4. unwarranted intrusion.

(2) Anticipatory guidance is part of the crisis intervention model. Counseling by a nurse specialist at the time of a stressful event (rape) may strengthen the patient's coping and prevent further problems. A nurse specialist in rape crisis intervention is educationally prepared in counseling techniques as well as crisis intervention with rape victims.

**110.** The death of a beloved spouse would place the surviving partner in which type of crisis?

1. maturational
2. reactive
3. adventitious
4. situational

(4) A situational crisis is an unexpected, unplanned event, such as death of a spouse. Option 1 represents a growth of development or normal maturational crisis; Option 2 is not a recognized crisis state. An adventitious crisis is one external to the body and that causes a massive upheaval of personal order.

**111.** The three major sequential maturational crises for females include:

1. puberty, pregnancy, and menopause.
2. death of a spouse, menopause, and childbirth.
3. rape, divorce, and menarche.
4. dating, engagement, and separation.

(1) The three major sequential maturational crisis affecting the female are puberty, pregnancy, and menopause. These are life events that have been studied by many researchers and are considered the major events in a woman's life. Puberty (onset menarche); pregnancy (turning point in one's life, from which there is no return); and menopause (cessation of menses). The nurse has the responsibility to assess, plan, implement appropriate concepts to facilitate effective functioning, and enhance growth and development. Options 2, 3, and 4 are not sequential maturational crises.

**112.** A female having her first child is experiencing which type of crisis event?

1. situational
2. maturational
3. adventitious
4. reactive

(2) A maturational crisis occurs when an individual arrives at a new stage of development and must develop new coping strategies. Situational crisis arises from sources external to individuals. An adventitious crisis occurs when some event external to the person disrupts coping behaviors (for example, floods or hurricanes). A reactive crisis is not a crisis intervention.

**113.** Which intervention would you take first to assist a woman who states that she feels incompetent as the mother of a teenage daughter?

1. Recommend that she discipline her daughter more strictly and consistently.
2. Make a list of things her husband can do to help her improve.
3. Assist the mother to identify what she believes is preventing her success and what she can do to improve.
4. Explore with the mother what the daughter can do to improve her behavior.

(3) The intervention priority with a mother who feels incompetent to parent a teenager (daughter) is to assist the mother to identify what she feels her crisis events are and to help with better coping skills and to teach mothering skills. With a teenager, the growth and development parameters have to be concentrated on self at this time as well as acquiring an added event. Options 1, 2, and 4 represent interventions that do not directly address the mother's feelings of inadequacy.

**114.** The mother of a newborn child is very upset. The child has cleft lip and palate. The type of crisis this mother is experiencing is:

1. reactive.
2. maturational.
3. situational.
4. adventitious.

(3) The arrival of the "nonperfect" child that the mother had not envisioned, places the mother in a situational crisis. Option 1 is not an type of crisis. Option 2 is an identified specific time period in normal development when anxiety and stress increases. Option 4 is a crisis that occurs outside the person's control so that the person has a disruption in social norms.

**115.** Crisis intervention is likely to be successful for the client because the client:

1. is experiencing disequilibrium that she finds uncomfortable.
2. is willing to allow others to make decisions for her.
3. is experiencing only low to moderate levels of anxiety.
4. has never resorted to seeking help before.

(1) A client in crisis is seeking anxiety reduction and is usually open to the active intervention of the therapist who may offer possible solutions to the crisis not previously considered by the client. The goal of crisis intervention is to assist the person in distress to resolve the immediate problem and regain emotional equilibrium. This problem solving hopefully leads to enhanced coping to deal with the future stressful events.

**116.** What technique might the nurse engaged in crisis intervention use that would not be used in traditional psychotherapy?

1. role modeling
2. advice giving
3. information giving
4. counseling

(2) The nurse working in crisis intervention must be creative and flexible in looking at another's situation and suggesting possible solutions for the client to consider. Giving advice is part of the more active role the crisis intervention therapist takes. It is permissible in order to decrease time spent in therapy. To intervene in a crisis effectively, a provider must demonstrate calmness, caring, and empathy. Because the person in crisis often is confused, the intervener must be able to identify the facts in a situation and think clearly to plan solutions. The intervener (nurse) assumes that the client will make appropriate decisions when given the necessary information and support. Crisis intervention requires a more directive approach than traditional therapies.

**117.** In which situation is there a potential for primary crisis intervention to occur?

1. teaching a beginning client stress reduction techniques
2. assessing the coping strategies used by a client who attempted suicide
3. supporting a client about to be discharged from a mental health unit to attend a day hospital program.
4. writing a nursing order for suicide precautions for a newly admitted client.

(1) Primary crisis intervention promotes mental health and reduces mental illness. The purpose of primary crisis intervention is to promote mental health; provision for education and teaching; advocacy, identification of stressors/coping behaviors; promoting wellness; and referrals when necessary. Options 2 and 4 are examples of secondary care that establish tertiary care, which provides support for those who are recovering from a mental illness.

**118.** Which of the following would be considered an adventitious crisis?

1. death of a child in labor
2. being fired from a job
3. retirement
4. a riot at a rock concert

(4) The rock concert riot is unplanned, accidental, violent, and not a part of everyday life. An adventitious crisis is one that occurs outside the individual. These crises affect many people who experience both acute and post-traumatic stress reactions. Options 1 and 3 are examples of situational crises, which are responses to a traumatic event that usually is sudden and unavoidable. This usually follows the loss of an established support. Option 3 is an example of a maturational crisis, which is precipitated by the normal stress of development and may occur at any transitional period in normal growth and development.

**119.** The role of the nurse in the crisis intervention in the hospital setting might be described by each of the following except:

1. occasional visit to client.
2. team objectives only.
3. nurse-directed.
4. flexibility.

(4) Flexibility is a personal quality that enhances nursing effectiveness as a crisis intervention therapist. The nurse must work with the client to identify alternatives that are compatible with the client's beliefs and personal values and traditions. The skills needed for crisis intervention include communication, active listening, assessment, collaboration, advocacy, documentation, consultation, teaching, and coaching. The nurse must quickly establish trust and build a therapeutic relationship.

**120.** A client reveals that he is so anxious that he cannot "think straight," because his wife has left him. To assess using coping skills, the nurse could say:

1. "I can see you're upset. You can rely on us to help you feel better."
2. "What would you like us to do to help you feel more relaxed?"
3. "In the past, how did you handle difficult or stressful situations?"
4. "Do you think you deserve to have things like this happen to you?"

(3) This option is the only one that assesses coping skills. Assessment of the client in crisis is the most important, and often the most difficult, step of crisis intervention. The nurse must identify the coping behaviors of the client and with the help of the client the strategies of open communication, using positive reinforcement to develop more adaptive coping and healthier functioning capacities after the crisis experience. Option 1 gives unrealistic reassurance; option 2 asks the client to decide on his own treatment at a time he "can't think straight" (by his own verbal communication); option 4 is concerned with self-esteem.

**121.** Which statement about crisis theory will provide a basis for nursing intervention?

1. A crisis is an acute, time-limited phenomenon experienced as an overwhelming emotional reaction to a problem perceived as unsolvable.
2. A person in crisis has always had adjustment problems and has coped inadequately in his/her usual life situations.
3. Crisis is precipitated by an event that enhances the person's self-concept and self-esteem.
4. Nursing intervention in crisis situations rarely has the effect of ameliorating the crisis.

(1) Ways of assessing crisis are derived from established crisis theory and constitute a sound knowledge base for the application of the nursing process to a crisis. An understanding of these areas of crisis theory enables application of the nursing process: types of crisis, phases of crisis, aspects of crisis that have relevance for nurses. A crisis is defined as an acute, time-limited phenomenon experienced as an overwhelming emotional reaction to a: stressful situational event, development event, societal event, or cultural event, or to the perception of that event.

**122.** Crises events are best described as:

1. crises are precipitated by multiple events.
2. crises for one person will be a crises for the next person.
3. crises are a chronic state of coping.
4. crises are short—lasting approximately 6 weeks.

(4) Crises are acute (not chronic) events that will be resolved in one way or another within brief time periods. Crises are usually precipitated by a specific identifiable event. Crises for one person may not be perceived as a crises by another person.

**123.** When a husband takes out his work frustrations and anger by abusing his wife at home, the nurse would identify this crisis as which type?

1. psychiatric emergency crisis
2. developmental crisis
3. anticipated life transition
4. dispositional crisis

(4) A dispositional crisis is a response to an external situational crisis. External anger at work is the dispositional crisis displaced to his wife through abuse. An anticipated life transition crisis is a crisis that is normal in the life cycle; transitional is one over which the person has no control. Developmental crisis occurs in response to triggering emotions related to unresolved conflict in one's life. This is called a developmental crisis based on Freudian psychology. Psychiatric emergency crisis is when the individual's general functioning has been severely impaired, and the individual has been rendered incompetent.

**124.** A patient who has suicidal intentions would be experiencing which class of crisis?

1. psychiatric emergency crisis
2. developmental crisis
3. anticipated life transition crisis
4. dispositional crisis

(1) Psychiatric emergency crisis is when an individual's functioning has become severely impaired as in an individual who contemplates suicide. Developmental crisis occurs in response to a situation that triggers emotions related to unresolved conflict in one's life; anticipated life transition crisis is a normal life cycle transition that may be anticipated, but the individual has no control; dispositional crisis is an acute response to an external situation stressor.

**125.** A patient and his girlfriend have an argument. Which behavior by the patient would indicate he is learning adaptability to problem solve his situational frustrations?

1. The patient says to the nurse, "Give me some of that medication before I end up in restraints."
2. When the girlfriend leaves, the patient goes to the exercise room and punches on a punching bag.
3. The patient says to the nurse, "I am going to dump that broad."
4. The patient says to the girlfriend, "You had better leave before I do something I'm sorry for."

(2) The ability to channel frustrations into an acceptable behavior shows that coping and problem solving (punching a bag is superior to punching the girlfriend). Option 1 demonstrates avoidance behavior that does not help the patient problem solve affectively. Option 3 is avoidance by staying away from the girlfriend. Option 4 does not show increased coping behavior. It demonstrates object removal before violence occurs (avoidance).

**126.** A crisis occurs when an individual:

1. perceives a stressor to be threatening.
2. has no support system.
3. is exposed to a precipitating stressor.
4. experiences a stressor and perceives coping strategies to be ineffective.

(4) A crisis is a stressor that the individual perceives as unrealistic. This is inadequate and ineffective in problem solving; the problem is unresolved, thus a crisis. Options 1, 2, and 3 are incomplete descriptors of a stressor.

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

1. emotional behavioral indicator
2. spiritual indicator
3. sociocultural indicator
4. intellectual indicator

(3) Socially, stress can alter a person's relationships with others. The nurse develops plans in collaboration with the client when possible, according to the client's state of health, level of anxiety, coping mechanisms, and sociocultural aspects. The nurse and client set goals to change the existing client responses to the stressor or stressors.

**128.** A corporate executive works 60 to 80 hours per week. The client is experiencing some physical signs of stress. The practitioner teaches the client to include 15 minutes of biofeedback. This is an example of which of the following health promotion interventions?

1. structure
2. relaxation technique
3. time management
4. regular exercise

(2) Biofeedback techniques can be used to quiet the mind, release the tension, and counteract responses of general adaptation syndrome or stress syndrome. Nurses in teaching the client relaxation techniques should also encourage clients to use these techniques when they encounter stressful health situations.

**129.** The client is assessed by the nurse as experiencing a crisis. The nurse plans to:

1. allow the client to work through independent problem solving.
2. complete an in-depth evaluation of stressors and responses to the situation.
3. focus on immediate stress reduction.
4. recommend ongoing therapy.

(3) A crisis is an acute, time-limited state of disequilibrium resulting from a situational, developmental, or societal source of stress. Utilizing the nursing process, the nurse should assist the client(s) to work through a crisis to its resolution and restore their precrisis level of functioning.

**130.** A client is having psychological counseling for problems in communicating with his mother. Which of the models of stress would her nurse benefit the most from in reference to this stressor?

1. adaptation model
2. stimulus-based model
3. transaction-based model
4. Selye's model of stress

(3) The transaction-based model is, according to Lazarus, a state that stimulus theory and response theory do not consider individual differences. He takes into account cognitive processes that intervene between the encounter and the reaction, and the factors that affect the nature of this process. He includes mental and psychological components or responses as part of his concept of stress (person—environment transactions).

**131.** A 26-year-old single woman is knocked down and robbed while walking her dog one evening. Three months later, she presents at the crisis clinic, stating that she cannot put this experience out of her mind. She complains of nightmares, extreme fear of being outside or alone, and difficulty eating and sleeping. What is the best response for the nurse to make?

1. "I will ask the physician to prescribe medication for you."
2. "That must have been a very difficult and frightening experience. It may be helpful to talk about it."
3. "In the future, you might walk your dog in a more populated area or hire someone else to take over this task."
4. "Have you thought of moving to a safer neighborhood?"

(2) The client receives support and an opportunity to discuss the experience. Options 1, 3, and 4 do not validate her experience or permit the discussion of feelings.

**132.** A 60-year-old widower is hospitalized after complaining of difficulty sleeping, extreme apprehension, shortness of breath, and a sense of impending doom. What is the best response for the nurse to make?

1. "You have nothing to worry about. You are in a safe place. Try to relax."
2. "Has anything happened recently or in the past that may have triggered these feelings?"
3. "We have given you a medication that will help to decrease these feelings of anxiety."
4. "Take some deep breaths and try and calm down."

(2) This provides support, reassurance, and an opportunity to gain insight into the cause of the anxiety. Option 1 dismisses the client's feelings and offers false reassurance. Options 3 and 4 do not allow the client to discuss his feelings, which he must do in order to understand and resolve the cause of his anxiety.

**133.** A 50-year-old single male is brought to the crisis unit by the police after having escaped unharmed from his apartment, which was destroyed by a fire caused by his smoking in bed. The nurse observes the client sitting silently, almost motionless. Several other clients in the waiting room have commented about the heavy odor of smoke around the man. Which of the following is the nurse's best approach to the client?

1. "Would you like to change your clothes? The odor of smoke must be very disturbing."
2. "You have been through a very difficult experience. Let's move into my office so we can talk."
3. "I hope you have learned your lesson today and have given up cigarettes."
4. "You must be considering yourself one very lucky man."

(2) The client is immobilized by his near-death experience, the loss of his home, and his responsibility for these situations based on his smoking. Because he cannot make decisions at this point, the nurse's direction is appropriate and

therapeutic. It also provides a tactful way to alleviate the odor of smoke in the waiting room. Options 1, 3, and 4 do not provide support or direction for the client during this crisis.

**134.** A 19-year-old nursing student preparing for final exams arrives at the student health center, accompanied by two friends. She has not slept all night, is sobbing hysterically, is hyperventilating, and states that she “cannot go on.” Which of the following is the best response for the nurse to make?

1. “Relax, we all felt this way. You will get through it.”
2. “Perhaps you need more time to study. Have you discussed this with your advisor?”
3. “You are pretty upset right now. Studying for finals can be very stressful. Let’s work on a plan that might be helpful.”
4. “You need to calm down. Nurses have to learn to take a lot of stress.”

(3) This provides support, reassurance, and a concrete plan for dealing with the issues. Option 1 provides false reassurance. Option 2 is unrealistic; a client in high anxiety cannot think coherently enough to respond to such a suggestion. Option 4 negates the client’s feelings and might cause further anxiety.

**135.** A 35-year-old married truck driver presents at a mental health clinic. Since losing his job 2 weeks ago, he has slept only a few hours a night and has lost 10 pounds. Pale and haggard, he has trouble answering questions and is easily distracted. Which is the best action for the nurse to take?

1. Ask him whether he has tried to find another job.
2. Determine his current and previous level of function and conduct a mental status examination.
3. Ask him whether he has ever sought mental health counseling before and whether or not he is taking any medications.
4. Ask about his family’s reaction to his job loss.

(2) This action assesses the client’s current level of function, emotional state, and stability. Options 1, 3, and 4 do not offer the client support or assist in evaluating his current status.

**136.** A 42-year-old homemaker presents in the emergency department with uncontrollable tension and anxiety, difficulty in eating and sleeping, and feelings of extreme insecurity. Her husband of 17 years has recently asked for a divorce. The client is crying hysterically and rocking in a chair in the hospital room. Which is the best response for the nurse to make?

1. “You must stop crying so we can discuss your feelings about the divorce.”
2. “Once you find a job, you will feel much better and more secure.”
3. “I can see how upset you are. Let’s sit in my office so we can talk about how you are feeling.”
4. “Once you have a lawyer looking out for you interests, you will feel better.”

(3) This response validates the client’s distress and provides an opportunity to talk about her feelings. Because clients in crisis have difficulty making decisions, the nurse must be directive as well as supportive. Option 1 does not provide the client with adequate support. Options 2 and 4 do not acknowledge the client’s distress. Moreover, clients in crisis cannot think beyond the immediate moment, so discussing long-range plans is not helpful.

**137.** A client on an inpatient psychiatric unit at a community mental health center appears agitated and says loudly, “Leave me alone.” What is the nurse’s best approach?

1. Say “OK” and walk away.
2. Summon help in case the client becomes aggressive.
3. Say nothing and pace with the client.
4. Say, “You sound upset. I’d like to help.”

(4) This demonstrates the nurse’s concern and encourages the client to discuss feelings. Given the likelihood of an increase in anxiety level, the client should not be left alone. An assumption of aggressiveness would probably escalate the client’s anxiety. Option 3 does not acknowledge the client’s emotional state.

**138.** Which of the following explains the *major difference* between normal anxiety and anxiety disorders?

1. Normal anxiety is constant; an anxiety disorder is intermittent and short-lived.
2. Normal anxiety is experienced as a natural human response; in an anxiety disorder, there is an impending sense of doom.
3. An anxiety disorder is seldom controllable and usually must run its course.
4. Normal anxiety is a fact of life and rarely becomes an anxiety disorder.

(2) During an anxiety reaction, the client thinks that something bad will happen; normal anxiety is experienced as a natural response. Both have physiologic and psychologic manifestations. Normal anxiety is not constant; there can be a side range of levels, from mild to severe. An anxiety reaction can be controlled with proper interventions to reduce the level of distress. Normal anxiety could become an anxiety reaction if stress renders normal coping mechanisms inadequate.

**139.** Lisa Dow comes to the university's health clinic complaining of anxiety, insomnia, and trouble eating. Which of the following criteria should the nurse use to develop a plan for care?

1. coherence of thought processes, reality, orientation, and anxiety
2. reduction of behavioral signs of nervousness and effective use of coping mechanisms
3. cycle of mood swings and their impact on self-care
4. self-reports of experiencing less fear

(2) The nurse must assess the psychologic and physiologic indicators of anxiety and the client's effective use of coping mechanisms. Incoherent thought processes, mood swings, and lack of reality orientation have not been the problem. Although self-reporting is important, a more comprehensive evaluation is in order.

**140.** The nurse in assessing a client must be able to identify the impact of the psychosocial spheres on both the development of illness and the client's response to illness. All of the following depict the interaction between stress and the organism except:

1. biological needs—changes in physiological functions.
2. interpersonal relationships—feelings of punishment.
3. sociocultural—mobilization of social structures.
4. psychological—feelings of hopefulness.

(4) Psychological stress results in feelings of deprivation: boredom, grief, sadness; feeling of anxiety, pressure, guilt; feelings of danger; sense of failure or hopelessness.

**141.** The following is the basic connecting link in the bridge between the mind and the body:

1. neurotransmitters.
2. stimulation of the parasympathetic nervous system.
3. biochemical steps—increase sugar and water.
4. mechanisms of stressors with the pathological condition.

(1) Neurotransmitters are the bridge between stress and the development of physical illness. All brain functioning, whether it involves thinking, feeling, or sending messages to the muscles of the limbs or organs, depends on the neurotransmitters.

**142.** The nursing diagnosis, self-esteem disturbance related to feelings of abandonment as evidenced by feelings of worthlessness has been established. Identify an appropriate short-term goal from the following:

1. Client will initiate social interactions with another client or staff daily by (date).
2. Client will verbalize two positive things about herself by (date).
3. Client will identify two personal behaviors that might push others away within 2 weeks.
4. Client will agree to take antidepressant medications regularly within 2 weeks.



(2) To be able to verbalize something positive about the self indicates improvement in self-esteem over the earlier feelings of worthlessness.

**143.** The nurse wishes to reinforce Mrs. Matthews esteem by acknowledging the improvement in her personal appearance. She's wearing a new dress and has combed her hair. The most appropriate remark would be:

1. "You look nice this morning."
2. "I like the dress you're wearing."
3. "What brought about this glamorous transformation?"
4. "You're wearing a new dress."

(4) Clients with low self-esteem often see the negative side of things. The meaning of compliments may be altered to "I didn't look nice yesterday" or "They didn't like my other dress." Neutral comments avoid negative interpretations.

**144.** To help a client meet the goal of improved self-esteem, the nurse should:

1. assist the client to identify and develop strengths.
2. encourage the use of PRN anxiolytic medications.
3. engage in power struggles as necessary.
4. encourage behavior changes only when client states that they are ready.

(1) Providing for successful outcomes in other areas of a client's life helps the client improve feelings of self-worth.

**145.** The major social support systems are:

1. willingness to call on others to help.
2. emotional assistance provided by others.
3. community support systems beneficial to the client.
4. support of the use of coping skills and verbalization for anger management.

(4) Support of the use of coping skills and verbalization for anger management is not a social support system. Options 1, 2 and 3 are all social support systems.

**146.** Support system enhancement includes all except:

1. determine the barriers to using support systems.
2. discuss with others concerned how they can help.
3. explore life problems of the support team before teaching.
4. involve spouse, family, and friends in the care and planning.

(3) The exploration of life problems of the support team before teaching is not necessary to enhance the support team. Options 1, 2, and 4 are all enhancements of the supportive system.

**147.** Support systems during the grieving process consists of the following:

1. the despondent friend.
2. the nurse.
3. the social worker.
4. the family.

(1) The despondent friend, even though this could be a support to the grieving person, is in a state of despondency and, therefore, would not do well with their grieving friend.

**148.** Mrs. Owens is the 81-year-old mother of Jonathan, who is 54 years old. Jonathan has had schizophrenia since he was 16 years old. Which of Mrs. Owens's concerns is likely to predominate?

1. Will my retirement funds outlast me?
2. Who will handle my funeral arrangements?
3. What will become of Jonathan when I am gone?
4. How can I get Jonathan's doctor to talk to me?

(3) The mother's most prominent concern will be what will become of her son after she dies. Option 1, although important, is not her most prominent concern. Option 2 is not likely to be the primary concern; the welfare of her son with schizophrenia is more important. Mrs. Owens has likely confronted and handled the concern about getting the doctor to talk to her after 38 years of managing her son's care. Her predominant concern will be what will become of her son after she dies.

**149.** Which of the following services is not part of family consultation?

1. assisting with vocational rehabilitation
2. providing information about the illness
3. teaching effective communication
4. helping families problem solve

(1) Family consultation does not involve vocational rehabilitation. It involves helping families deal with their feelings, focus on the problems, and find solutions. Providing information about the illness is a component of family consultation. Teaching effective communication is a component of family consultation. Helping families problem solve is a component of family consultation.

**150.** What is the primary goal of family education?

1. symptom reduction
2. improved quality of life
3. increased knowledge about mental illness
4. improved care-giving skills

(2) Improving quality of life is the primary goal of family education. Symptom reduction was one goal of psychoeducation, not family education. Increased knowledge about mental illness may accompany family education but is not a goal of it; improved quality of life and reduced family burden are the goals. Improved care-giving skills may accompany family education, but is it not a goal of it.

**151.** Families receiving family consultation, unless proven otherwise, are considered:

1. to be healthy and competent.
2. to lack knowledge and skills.
3. to have the client's best interests at heart.
4. all of the above.

(4) Family consultation is based on the assumptions that the family dealing with the mental illness of a loved one is healthy and competent, lacks knowledge and skills about how to manage the ill member, and has the client's best interests at heart.

**152.** When a person with serious mental illness becomes violent, who is the most likely target?

1. a mental health professional
2. a police officer
3. a stranger
4. a family caregiver

(4) Historically, the target of violence is a family caregiver, not a mental health professional, police officer, or stranger.

**153.** Why is it necessary for the family consultant (nurse) to be clear in communicating with family members?

1. Some families do not speak English.
2. Family members may be preoccupied.
3. Family members may be experiencing communication deviance.
4. The consultant (nurse) may not remember what was said.

(2) The need for clarity is important because family members are under stress, preoccupied, and anxious. The need for clarity is not about language barriers; it is about a family's stress level when a member is in crisis. Communication deviance is an outdated concept. Family members may struggle with their own cognitive issues. The object of clarity in communication is the client's family, not the consultant.

**154.** A daughter of an 82-year-old woman is the prime support of her mother. Which agency should the nurse suggest for the daughter's relief for a few hours and to help this client?

1. social daycare center
2. assisted-living care center
3. maintenance daycare center
4. skilled nursing facility

(1) The social daycare center would relieve the daughter for a few hours as well as give this client some socialization. Unless this client has needs and/or desires to go to an assisted living or skilled nursing facility, these places are not relevant at this time. Option 3 would not meet the needs of this client at this time.

**155.** The focus of hospice care is:

1. have the client in the hospital where experts can watch the client.
2. have the client free of all fears.
3. have the client close to his/her family.
4. have the client seek expert care.

(3) The focus of hospice care is on keeping the client comfortable, free of pain, as active as possible, and close to his/her family.

**156.** Support of the older person is very important because of all of the following except:

1. social isolation can exist.
2. suicide is high in the elderly.
3. illness may be present with no caretakers.
4. athletic events cannot be attended.

(4) These events (athletic) may not be important to the client or be physically challenging for them to go to; support systems are essential for helping, protection, social, transportation, and other needs that present themselves. This is also a caring behavior for the older person.

**157.** What are the major roles that families might play in the treatment of clients?

1. Be the communicators and cultural supporters.
2. Make all decisions about the care.
3. Provide constant vigilance for falls.
4. Provide "play" therapy during hospitalization.

(1) In a cross-cultural nursing situation, family may serve as interpreters; communicators on behalf of the client; may have authority to work with the client on decisions (family structure) about the illness and treatment factors; may bring

personal belongings from home, make contact with rituals, ministers, or other requested persons; and may provide caring support of the client.

**158.** A Native American has been hospitalized on the medical unit and requests that the tribal shaman be involved in treatment. The nursing implementation that would be most appropriate in this situation would be:

1. explain to the client that this is not appropriate in medical treatment.
2. facilitate the client's request by reporting to the treatment team.
3. ignore the client's request as it is not possible to do this.
4. reflect that the client is seeking magical healing rather than relying on self.

(2) Native Americans often believe in the special healing abilities of a religious shaman. The client's request is congruent with cultural beliefs and should be honored. The nurse can help facilitate this request by acting as the client's advocate. Option 1 is a value judgment on the nurse's part; it is not appropriate to tell the client this. Option 3 would be disrespectful and nonaccepting of the client's beliefs; this would ruin the nurse-client relationship. Option 4 would be an interpretive response based on the nurse's belief system; it does not accurately reflect the client's culture.

**159.** A unit that includes the nuclear family as well as other relatives (aunt, uncles, cousins, and grandparents) who are committed to maintaining family and close support system is:

1. intragenerational/extended family.
2. single/foster family.
3. nuclear family.
4. binuclear family.

(1) In some cultures, and as people live longer, more than two generations may live together. Family living in this way provides supportive systems of several generations; the relatives of nuclear families (aunts, uncles, cousin, and grandparents) compose the extended family. Foster family includes the temporary placement of children who no longer live with the birthparents; nuclear family is a structure of parents and their offspring.

**160.** Healthcare that focuses on the health of the family as a unit, as well as the maintenance and improvement of health and growth of each person in the unit is:

1. closed system.
2. communal system.
3. open system.
4. family-centered system.

(4) Family-centered nursing focuses on family structure, family roles and functions, physical health status, communication, values, support and coping resources. Options 1, 2, and 3 deal with the make-up and kind of family unit, not nursing interventions.

**161.** The healthy family is a(n) \_\_\_\_\_ system with complex interactions and supports both within the family and in the external world.

1. family
2. open
3. closed
4. system

(2) An open system has a high degree of awareness of each member's needs, is able to support members in crisis, and has open channels of communication.

**162.** Mutual support and self-help groups arose because:

1. people like to meet in “like” groups.
2. people wanted a lot of support.
3. no support existed at home.
4. needs were not met by existing healthcare system.

(4) Mutual support/self-help groups focus on nearly every major health problem or life crisis people experience. These groups arose because people felt their needs were not being met by the existing healthcare system.

**163.** Using clichés in therapeutic communication leads the patient toward:

1. viewing the nurse as human.
2. accepting self as human.
3. self-disclosing.
4. feeling discounted.

(4) The use of clichés is commonly construed by the patient as the nurse’s lack of understanding, involvement, and caring; thus, the patient may feel demeaned and discounted.

**164.** In assessing the patient, the nurse begins by asking questions that encourage the patient to describe problematic behaviors and situations. The next step is to elicit the patient’s:

1. feelings about what has been described.
2. thoughts about what has been described.
3. possible solutions to the problem.
4. intent in sharing the description.

(2) Questions should be asked in a precise order, specifically from the most simple description to the more difficult disclosure of feelings. When the problem has been described, eliciting the patient’s thoughts about the dilemmas provides further assessment data as well as the patient’s interpretation of what has happened. Feelings, solutions, and articulating intent (why information is shared at a particular moment) are more complex processes, especially if the patient is highly anxious or out of touch with reality.

**165.** A patient on your unit tells you that his wife’s nagging really gets on his nerves. He asks whether you will talk with her about her nagging during their family session tomorrow afternoon. Which of the following responses would be the most therapeutic to the patient?

1. “Tell me more specifically about her complaints.”
2. “Can you think why she might nag you so much?”
3. “I’ll help you think about how to bring this up yourself tomorrow afternoon.”
4. “Why do you want me to initiate this in tomorrow’s session rather than you?”

(3) The patient needs to learn how to communicate directly with his wife about her behavior. Your assistance will enable him to practice a new skill and will communicate your confidence in his ability to confront this situation. Options 1 and 2 inappropriately direct attention away from the patient and toward his wife, who isn’t present. Option 4 implies that there might be a legitimate reason for you to assume responsibility for something that rightfully belongs to the patient. Instead of focusing on his problems, he’ll waste precious time convincing you why you should do his work.

**166.** During the work phase of the nurse-patient relationship, the patient says to her primary nurse, “You think that I could walk if I wanted to, don’t you?” What would be the nurse’s best response?

1. “Yes, if you really wanted to, you could.”
2. “Tell me why you’re concerned about what I think.”
3. “Do you think you could walk if you wanted to?”
4. “I think you’re unable to walk now, whatever the cause.”

(4) This response answers the question honestly and nonjudgmentally and helps to preserve the patient's self-esteem. Option 1 is an open and candid response but diminishes the patient's self-esteem. Option 2 doesn't answer the patient's question and is not helpful. Option 3 would increase the patient's anxiety, because her inability to walk is directly related to an unconscious psychological conflict that has not been resolved.

**167.** A basic tool the nurse uses when establishing a relationship with a client with a psychiatric disorder is:

1. narcissism.
2. role blurring.
3. self-reflection.
4. making value judgments.

(3) Self-reflection is a means of assisting people to better understand their own thoughts and feelings. Reflecting may take the form of questions or simple statements that convey the nurse's observations of the client when sensitive issues are being discussed. The nurse helps make the client aware of inner feelings and encourages the client to own them.

**168.** Which communication technique would yield positive results within the text of a therapeutic relationship?

1. advising
2. giving approval
3. active listening
4. asking "why" questions

(3) People want more than just physical presence in human communication. Most people are looking for the other person to be there for them psychologically, socially, and emotionally. Active listening includes observing the client's non-verbal behaviors, listening to and understanding the client's verbal messages, listening to and understanding the person in the context of the social setting of his or her life, listening for "false notes" (that is, inconsistencies), and providing clients feedback about themselves of which they might not be aware.

**169.** When beginning a relationship with a client, which advice will be helpful establishing rapport?

1. Fill any silences the client leaves.
2. When in doubt, focus on feelings.
3. Rely on direct questions to explore sensitive areas.
4. Pay more attention to verbal than nonverbal communication.

(2) Helping a person with emotional or medical problems is rarely a straightforward task. The goal of assisting a client to regain psychological/physiological functional normality can be difficult to achieve. Extremely important is permitting the client to set the pace. The content and direction of the interview are decided by the client. The nurse provides the opportunity for the client to set and reach specific goals. Also, the nurse shows respect, interest, empathy, and support of the client.

**170.** A nurse behavior that jeopardizes the boundaries of the nurse-client relationship is:

1. focusing on client needs.
2. suspending value judgments.
3. recognizing the value of supervision.
4. allowing the relationship to become social.

(4) Barriers to communication for the nurse are failure to listen, improperly decoding the client's intended message, and placing the nurse's needs above the client's needs. Examining the patient's behavior from a therapeutic perspective is a professional obligation and has no place in social interaction. The therapeutic relationship is client- and goal-oriented, whereas with the social relationship, there may not be a specific purpose.

**171.** Which statement describes an event that would occur during the working phase of the nurse-client relationship?

1. The nurse summarizes the objectives achieved in the relationship.
2. The nurse assesses the client's level of psychological functioning, and mutual identification of problems and goals occurs.
3. Some regression and mourning occur, although the client demonstrates satisfaction and competence.
4. The client seeks connections among actions, thoughts, and feelings and engages in problem solving and testing of alternative behaviors.

(4) The phases of the nurse-client relationship include orientation, working, and termination phases. During the orientation phase a trusting, honest, respectful, and understanding therapeutic relationship is accomplished. The client understands the purpose, and confidentiality is discussed. During the working phase of the relationship, the nurse and client begin to view each other as unique individuals. A caring, concerned relationship should be established as well as the welfare of the client considered. The working phase has two major stages: exploring and understanding thoughts and feelings and facilitating and taking action. The nurse helps the client to explore thoughts, feelings, and actions and helps the client to plan a program of action to meet pre-established goals. The termination phase should be open and honest. Goals and final help may be necessary as referrals or follow-up. This phase concludes the relationship.

**172.** What behavior on the part of Mr. Jones will produce the evaluation that the termination of the therapeutic nurse-client relationship has been handled successfully?

1. The nurse gives his/her personal phone number and permission to call after discharge.
2. The nurse avoids upsetting the client by gradually focusing on other clients beginning one week prior to his discharge.
3. The nurse summarizes with Mr. Jones the changes that have happened during their time together and evaluates goals attainment.
4. The nurse offers to meet Mr. Jones for coffee and conversation three times a week for two weeks after his discharge.

(3) Summarizing and evaluating progress helps validate the experience for the client and the nurse and facilitates closure. Termination must be discussed; avoiding discussion by spending little time with the client promotes feelings of abandonment. Successful termination requires that the relationship be brought to closure without the possibility of dependency producing ongoing contact.

**173.** Which statement best describes a therapeutic relationship?

1. The focus is on the client; problems are discussed by the nurse and client; solutions are implemented by the client.
2. The focus shifts from nurse to client; advice is given by both parties; solutions are implemented by each.
3. The focus is socialization; mutual needs are met; feelings are shared.
4. The focus is the creation of a partnership whereby each member is concerned with growth and satisfaction of the other.

(1) Therapeutic communication promotes understanding and can help establish a constructive relationship between the nurse and the client. The therapeutic helping relationship is client-goal directed. Options 2, 3, and 4 describe events that occur in social or intimate relationships.

**174.** Within the context of the nurse-client relationship, congruence on the part of the nurse implies:

1. encouraging the client to depend on the nurse for support and reassurance.
2. consistently making value judgments.
3. extensive self-revelation.
4. genuineness in using therapeutic communication tools in a spontaneous manner.

(4) In congruent communication, the verbal and nonverbal aspects of the message match. Clients more readily trust the nurse when they perceive the nurse's communication as congruent. This will also help to prevent miscommunication. Congruence between verbal expression and nonverbal expression is easily seen by the nurse and the client. Congruence is a desirable characteristic involving spontaneous genuineness. Options 1, 2, and 3 are undesirable in a therapeutic relationship.

**175.** The orientation phase of a nurse-client relationship has as a major task:

1. establishing rapport.
2. socializing.
3. guiding the client to try out new behaviors.
4. setting limits on incongruent messages.

(1) Before the client can work to identify and resolve critical issues, a trusting relationship must be established between the nurse and the client. Establishing rapport is part of that process. Socialization is not a primary task of a therapeutic relationship. Trying out new behaviors occurs during the working phase. Incongruent messages should be recognized and explored, rather than forbidden.

**176.** The nurse is taking a nursing history on an adolescent client. The nurse can best facilitate communication with the adolescent client by making which of the following statements?

1. "If you read the pamphlet, you'll know all you need to know."
2. "We can talk about this with your mother."
3. "Other teenage girls also feel depressed."
4. "Tell me about the last time you had sexual intercourse."

(3) Option 3 indicates that the client is not alone, which can enhance communication by affirming the client's feelings. Adolescents will feel more willing to discuss private issues if parents are not present and if they understand that their concerns are common with other teens. Questions should be sensitively worded rather than intrusive as in option 4. Written instructions should supplement teaching rather than being the primary vehicle for teaching.

**177.** A rationale for implementing group therapy immediately after meals on an eating disorders treatment unit is to:

1. promote processing of anxiety and maladaptive behaviors associated with eating.
2. shift the clients' focus from food to psychotherapy.
3. prevent occurrence of maladaptive behavior such as purging.
4. focus on weight control mechanism and food preparation.

(1) Eating produces high anxiety for all clients with eating disorders. Anxiety levels must be lowered if the client is to be successful in attaining therapeutic goals. Groups exist to help people achieve goals (outcomes) that would be unattainable by individual effort alone.

**178.** An 11-year-old is seeing a nurse-counselor to help her deal with the death of a maternal grandmother. The nurse-counselor should expect this child to make which of the following statements?

1. "I wonder if Grandma will ever come back?"
2. "I think I'll start going to church with Mom now."
3. "I'm not ever going to die; it makes everyone too sad."
4. "I wonder if I'll die of a heart attack, too?"

(4) At the developmental age of 11 years old, the child understands death as the inevitable end of life. Also, the child begins to understand her own mortality, expressed as an interest in afterlife or as fear of death. Assisting the child with the grief experience includes helping the child regain the normal continuity and pace of emotional development. Children can feel afraid, abandoned, and lonely. Careful work with bereaved children is especially necessary because experiencing a loss in childhood can have serious effects later in life.



**179.** The nurse has been working with a family by using crisis intervention techniques. The nurse is concluding her care with the family and asks the family to complete the final step of the process. The nurse should ask the family to:

1. identify alternatives.
2. choose from among the alternatives.
3. accept what they cannot change.
4. evaluate outcomes.

(4) Crisis Intervention is a short-term helping process of assisting clients to work through a crisis to its resolution and restore their precrisis level of functioning. It is a process that includes not only the client in crisis but also various members of the client's support network. Working with another person increases the likelihood that the person in crisis will resolve it in a positive way. Often a state of crisis offers the individual or family great potential for growth and change.

**180.** Considering her negative pattern of thinking, Mrs. Martin's nurse-therapist believes the therapy of choice for her is:

1. psychoanalytic therapy.
2. behavior therapy.
3. cognitive restructuring therapy.
4. group therapy.

(3) Cognitive therapy attempts to alter the client's dysfunctional belief focusing on positive outcomes rather than negative attributions. The client is also taught the connection between thoughts and resultant feelings. This is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders—for example, depression, anxiety, phobias, and pain problems. It is based on an underlying theoretical rationale that individuals' effect and behavior are largely determined by the way in which they structure the world.

**181.** The most effective nursing strategy to assist a client in recognizing and using personal strength includes:

1. encouraging the client's self-identification of strengths.
2. promoting the client's active external thinking.
3. listening to the client and providing advice as needed.
4. assisting the client in maintaining an external locus of control.

(1) The nurse collaborates with the client to create a plan of care that includes appropriate goals and ways to meet identified goals. Possible outcomes will include the client's self-identification, with increased self-esteem by verbalizing of positive elements of self.

**182.** Appropriate nursing strategies to assist a client in maintaining a sense of self include:

1. using the client's first name when addressing the client.
2. treating the client with dignity.
3. explaining procedures only if the client is attentive.
4. discouraging the use of personal items.

(2) Nursing strategies should always include treating the client with dignity, respect, and honor.

**183.** A successful resolution of the nursing diagnosis "Negative self-concept related to unrealistic self-expectations" is when the client can:

1. report a positive self-concept.
2. identify negative thoughts.
3. recognize positive thoughts.
4. give one positive cue with each negative cue.

(3) When the nurse determines how the client perceives himself, effort should be directed to reinforce self-worth and promote a positive self-concept, including helping a client to identify areas of strengths. Assisting the client to evaluate himself and make behavior changes is also a nursing intervention.

**184.** A client who recently lost 50 pounds just received news that she is pregnant. A possible nursing diagnosis is:

1. actual chronic low self-esteem related to obesity.
2. potential chronic low self-esteem related to obesity.
3. actual situational low self-esteem related to fear of weight regain and pregnancy.
4. potential situational low self-esteem related to fear of weight regain and pregnancy.

(4) If there are indications of a body image disturbance, the assessment should include body disturbances, related to a functional or physical problem. The disturbance may be an anticipated one; for example, weight gain and pregnancy. Stressors can include: change in physical appearance, sexuality concerns, or unrealistic ideal self.

**185.** An appropriate question when assessing a client's self-expectations about weight loss is:

1. "What makes you think you can change your eating habits?"
2. "How do you feel about losing weight?"
3. "How important is it that you lose weight?"
4. "What do you think is a realistic weekly weight loss for you?"

(4) Nurses should assist clients to evaluate themselves and make behavior changes. Listening to the client, supporting the client's strengths, and assisting her to look at herself in totality as well as encouraging the setting of attainable goals should be part of the nurse-client relationship.

**186.** When assessing the possible impact a mastectomy may have on the client, an appropriate comment is:

1. "Can you tell me how this surgery will change the way you feel about yourself?"
2. "Your breasts are important to you, aren't they?"
3. "Why are you so concerned with your appearance?"
4. "Tell me about your illness."

(1) Encourage client's verbalization of feelings about mastectomy, assess coping status, allow for client's input regarding care; be supportive of client's effective coping behaviors; allow client to respond to loss of body part and changed body image with grieving behaviors.

**187.** A client is unable to describe himself in any positive way and accentuates his weaknesses. A possible nursing diagnosis can be based upon the client's:

1. positive self-concept.
2. negative self-concept.
3. high self-esteem.
4. low self-esteem.

(2) Self-esteem is one judgment of one's own worth, that is how that person's standards and performances compare to others and to one's ideal self. If a person's self-esteem does not match with the ideal self, then low self-conception results.

**188.** When counseling a client on factors that affect self-concept, which of the following statements denotes a possible misunderstanding?

1. "Having a good job means a lot to me."
2. "My parents instilled strong beliefs in me."
3. "It's important to me to be the best in all I do."
4. "My Hispanic background doesn't affect anything about me."

(4) It is the nurse's responsibility to use therapeutic communication and remain sensitive to the effect that cultural influences will have on the client's behaviors and needs. Cultural background is not only assessed directly but is also considered as a factor in the areas of self-perception, role relationships, major stressors, and coping strategies.

**189.** An overweight client experiencing low self-esteem may be having difficulties with which step in the formation of self-concept?

1. positive separation of self from the environment
2. externalization of other people's attitude toward self
3. internalization of societal standards
4. rejection of societal standards

(1) Behaviors indicating negative resolution include: failure to develop a personal identity (the conscious sense of individuality and uniqueness that is continually evolving throughout life); a strong sense of identity that has integrated body image, role performance, and self-esteem into a complete self-concept (the infant learns that the physical self is separate and different from the environment).

**190.** In Erikson's Stages of Psychosocial Development, behaviors indicating positive resolution are all of the following except:

1. completing a task after it has been started.
2. establishing close interpersonal relationships.
3. establishing a priority of needs, recognizing both self and others.
4. demonstrating others thoughts as words.

(4) Erikson's Stages of Psychosocial Development largely determines the development of self-concept.

**191.** The question "Are you able to look at yourself in the mirror and like what you see?" is asking about which dimension of self-concept?

1. self-concept
2. self-expectation
3. self-evaluation
4. self-orientation

(3) Self-evaluation includes the sum of a person's conscious and unconscious attitudes about his or her body. Self-esteem is one's judgment of one's own worth, that is, how that person's standards and performance compare to others and to one's ideal self.

**192.** A client who recently lost 100 pounds continues to shop for clothes in her "old size." This is an example of disruption of:

1. body image.
2. personal identity.
3. self-expectation.
4. core self-concept.

(4) The client has an inappropriate view of her physical self. Personal identity is a sense of uniqueness; self-expectation are those things one believes the self should be able to do; and core self-concept are the most vital central beliefs about one's identity.

**193.** An adult who has failed to satisfactorily resolve the developmental task of adolescence—identity versus confusion—may show which behavior?

1. asserts independence
2. is unable to express personal desires
3. has difficulty working as a member of a team
4. goes along with the crowd in all activities

(4) A person who asserts independence (rather than follows the crowd) is demonstrating successful resolution of this task. Inability to express desires is symptomatic of unresolved toddlerhood autonomy versus shame and doubt, while difficulty being a team player suggests unresolved early school-age industry versus inferiority.

**194.** When a patient with anorexia nervosa is hospitalized for a weight restoration program, the nurse would expect lower extremity edema to be related to:

1. liver dysfunction.
2. compromised renal function.
3. endocrine imbalance.
4. poor cardiac function.

(4) When refeeding a patient, the increased volume of the circulatory system places a strain on a depleted cardiac muscle mass, leading to cardiovascular collapse. Mortality is a significant factor for these patients (5—7 percent). Monitoring the refeeding process is very important, and a strict intake must be watched closely under the supervision of the health team.

**195.** Which of the following patients would be at greatest risk for hypokalemia?

1. a nonpurging bulimic
2. an anorexic who loses weight by restricting food intake
3. an anorexic who purges to lose weight
4. a patient with any eating disorder

(3) When one purges to promote vomiting, hydrochloric acid and  $K^+$  are lost from gastric content, leading to  $K^+$  deficiency.

**196.** Which of the following medications is most likely to be used in managing patients with eating disorders?

1. an antidepressant, such as fluoxetine
2. a neuroleptic, such as risperidone
3. an anticonvulsant, such as dilantin
4. an anxiolytic, such as Xanax

(1) An antidepressant, such as Prozac, has been found helpful in increasing the rate of weight gain and decreasing relapse occurrence. These medications are best used in later treatment, and the patient's weight should be constantly monitored because some SSRI may cause weight loss.

**197.** When performing a nursing history of adolescents with eating disorders, which risk factor is most commonly identified?

1. excessive exercise
2. purging
3. dieting
4. overeating

(3) Most patients with eating disorders have a fear of being “fat,” so these patients are always on a diet. The key concepts are: the drive for thinness and emotional response to cues either internal or external. The causes can be age onset, ethnic and cultural environment, and family relationships.

**198.** In caring for a male client who has recently had his left leg amputated, what subjective data should the nurse collect to assess body image?

1. his feelings regarding surgery
2. his description of his personality
3. status of wound healing
4. strength of the femoral pulses, bilaterally

(1) In assessing body image, the nurse must gather data about the perception of his body. The nurse must assess all parameters, psychological, biological, cultural, environmental factors. These areas will help the nurse formulate a plan of care.

**199.** Which of the following characteristics, when observed in a client, should a nurse recognize as most likely related to having been raised in a family of four or more children?

1. difficulty managing financial resources
2. ability to negotiate compromise
3. inability to share space and possessions
4. refusal to accept responsibility

(2) Clients raised in families with four or more children have learned cooperation, compromise, tolerance, and how to handle peer pressure. Children raised in this environment learn to be thrifty and to manage their resources and material goods. It is also common for children of large families to learn to share their time, space, and possessions. Because children from large families have to do more, they learn how to accept increased responsibility not only for themselves but for others.

**200.** When teaching couples who are expecting a multiple birth about time management, the nurse should include all of the following strategies except:

1. use a diaper service if using cloth diapers.
2. heating bottles before each feeding is not necessary.
3. give each baby a bath every other day (one baby per day).
4. to avoid poor breast feeders do not alternate breast and bottle-feeding.

(4) Breastfeeding more than one baby at a time can be a challenge in many ways: amount of time it takes to breastfeed two babies, amount of breast milk present, sore nipples, and so on. It is better to encourage the mother to alternate breast and bottle-feeding than to give up on breastfeeding entirely. This does not mean the babies will be poor breast feeders. The babies will learn to adapt to the alternate feedings. Options 1, 2, and 3 are good options for parents of multiple births as they save energy and time expended in the physical care of the baby without compromising quality of care.

**201.** Which of these factors, when identified in adoptive parents, would the nurse identify as a major determinant of an adopted child's adjustment and development?

1. marital harmony
2. socioeconomic status
3. occupational status
4. age of parents

(1) Marital harmony of the adoptive parents is one of the major determinants of an adopted child's adjustment and development. Other major determinants are the parents' personal qualifications, their love of the child, their acceptance of the child, and whether or not the child has friends. Factors that have been determined not to be predictive of adjustment include options 2, 3, and 4 as well as the presence or absence of biological siblings, health of the adoptive parents, religion, and prior experience the adoptive parents have had with children.

**202.** When a family adopts a child with special needs, which of the following behaviors by the child would the nurse identify as indicative of the “storm period?”

1. Visits with the prospective parents.
2. Child is on best behavior.
3. Child may have tantrums.
4. Child attends to outside interests.

(3) There are several phases to the adoptive process. The storm period occurs after the adoptive parents and child have courted each other and decided to proceed with the adoption. The storm period also follows the initial honeymoon phase of the adoption. During the storm phase, the child may have tantrums, may try to run away and even reject the overtures of love and acceptance by the adoptive family. During the courting phase, the child, parents, and other members of the family meet each other, visit, and are counseled about the adoption. A decision will be made at the end of this phase whether or not to proceed with the adoption. In the honeymoon phase, parents and child alike are on their best behavior. Household routines are changed to accommodate the adopted child, and discipline may be minimal. The final phase in adoption is of adaptation and adjustment. All family members have agreed that they can live and work together and begin to pursue outside interests without disrupting or threatening the status of the family.

**203.** All of these statements made by an adoptive parent would indicate to the nurse that the family is experiencing stress related to the adoption except:

1. “Every time I look at my adopted child, it reminds me that we were unable to have a biological child.”
2. “I am so grateful to have been chosen as an adoptive parent and feel a responsibility to be a good parent.”
3. “It really makes me sad when people talk about my real child versus my adoptive child.”
4. “We have the same reward system for our biological and adoptive children.”

(4) Statement number 4 indicates that the family makes no distinction between the adoptive child and biological children in how they reward them or in how competition is fostered. Favoritism toward a biological child can create stress within the adoptive family. Statement number 1 indicates that the parent continues to struggle with infertility issues and places the child at risk for rejection, hostility, or a sense of inferiority projected onto them. Statement number 2 reflects the increased sense of responsibility for parenting because they were chosen adoptive parents. This is a common difficulty of adoptive parents. The being chosen concept can lead to problems such as difficulty in setting limits, increased stress in the parenting role, and being oversensitive to the needs of the adoptive child. The thoughts and concerns expressed in statement number 3 are common but stressful attitudes that will most likely be present for their entire life. Friends, family, and acquaintances within the community will distinguish between biological and adoptive children in the conversations and undermine the sense of belonging for which the child and parents strive.

**204.** Which of the following tasks, when completed by a middle-class North American family, would the nurse recognize as an indication the family is in the life cycle stage of families in later life?

1. beginning shift toward joint caring for older generation
2. realignment of relationships to include spouse
3. dealing with disabilities and death of parents
4. dealing with the loss of spouse and siblings

(4) Families in later life is the last family life cycle stage for middle-class North American families. Several changes or tasks must be accomplished in this stage, including dealing with the loss of spouse, siblings, and peers and preparing for their own death. When a family is beginning to shift toward joint caring for older-generation members, they are in the families with adolescents stage. Realignment of relationships to include the spouse is a task for the second family life cycle stage, the joining of families through marriage. Dealing with disabilities and the death of parents is next to last in the family life cycle stages, the launching children and moving on stage.

**205.** Which of the following statements, when made by a middle-class North American, would indicate to the nurse the client is making the emotional transition necessary to complete the “launching children and moving on” stage?

1. “Since the kids have gone to college, my spouse and I argue about even the little things.”
2. “Even though the kids are grown and married now, I volunteer to do their laundry or clean the house.”
3. “It makes me feel a little envious when my daughter takes the grandkids to her in-laws house.”
4. “I try to take my parents to the grocery store at least once a week and check on them every day.”

(4) Accepting a multitude of exits and entries into the family system is the key emotional transition necessary for families in the launching children and moving on stage. Several tasks help accomplish this transition. In this stage, families must deal with the disabilities and death of their parents. Option 4 indicates to the nurse that there is a recognition that the aging parents need assistance, and efforts are being made to accommodate that. Another task for this stage is the renegotiation of the marital system as a dyad. When children leave the home and the mother and father remain, it takes some time to renegotiate their roles and expectations. Statement 1 indicates this transition has not yet been made, because there is on-going disagreement about even the little things. Families in this stage also have to come to new relationships between the grown children and their parents. If a parent is continuing to check on them every day and perform activities of daily living for them, then launching hasn’t yet occurred. Families in this stage also have to figure out how to include their child’s in-laws and grandchildren. Option 3 indicates there is still some emotional distress on this point, and the transition has not yet been made.

**206.** Which nursing intervention should assume priority for a client who is separated but not yet divorced from their spouse?

1. Assist the client in making a visitation plan with the spouse’s extended family.
2. Assess the client’s current progress in mourning the loss of the nuclear family.
3. Encourage the client to retrieve hopes, dreams, and expectations.
4. Discuss strategies for restructuring the parent-child relationship.

(2) Separation is the third phase in moving toward a divorce. Prior to separation, a client has to have decided to divorce, planned the break-up of the family system, and then separate. Divorce will follow. Each phase has an emotional transition that must be completed before specific tasks can be accomplished. All of the options listed are tasks that must be completed, but it is not appropriate for the nurse to work on a task with the client if previous tasks have not been met. The correct order of the tasks listed is 2, 4, 1, and 3. Option 3 will occur after the divorce.

**207.** When comparing professional families to those from low-income families, which of the following outcomes is most likely related to having been raised in a low-income family?

1. becomes a grandparent between 31–35 years of age
2. develops as a nuclear couple, separate from parents at 26–30 years of age
3. graduated from high school
4. intense work involvement by 26–30 years of age

(1) Young women raised in low-income families tend to have their first child by 17 years of age, a second by 21, and the third by 25; then they become grandparents by age 35. Options 2, 3, and 4 are all characteristics of children raised by professional families. These children graduate from high school, attend graduate school, and are heavily involved in their work, establishing careers by age 30. In the second half of their 20s, children of professional families tend to establish their own nuclear family and separate from their parents.

**208.** Which nursing intervention would be most appropriate to meet the expected outcome of identifying the effects of one family member’s behavior on another in the affective domain of family functioning?

1. “How do you make sense of your spouse not visiting your child in the hospital?”
2. “What do you know about the effects of your child’s illness?”
3. “How does it make you feel when you hear your child cry during their treatment?”
4. “What do you do when your spouse doesn’t visit your child in the hospital?”

(3) The affective domain is about feelings. Option 3 is the only intervention that is directed at identifying how the client feels. Options 1 2 both are cognitive interventions as they identify what a client knows or how they think about a situation. Option 4 identifies behavior. All of the options are circular questions designed to change or intervene in how a family functions.

**209.** Which nursing intervention, in the form of a circular question, would be most effective to assist a family exploring future options and alternatives within the cognitive domain of family functioning?

1. “What’s the best advice that you’ve had about how to manage your child’s illness?”
2. “What information would be the most helpful in managing your son’s illness?”
3. “What do you think will happen if your spouse continues to refuse treatment?”
4. “How does your father show that he is afraid of becoming disabled?”

(3) Option 3 is the only question that causes the family member to look into the future and think about what will happen. By doing this, the family member can move toward strategies to cope or plans for assistance. Options 1 and 2 are cognitive interventions aimed at helping the family explore differences between ideas and beliefs, relationships, time, and people. Option 4 is also an affective intervention.

**210.** Which would be the best approach for a nurse to take when asking a third person about the relationship between two other family members for the purpose of intervening in the behavioral domain of family functioning?

1. “How does your dad take care of your sister?”
2. “When your dad supports your sister, how does your brother feel?”
3. “What do you think your dad needs to do to prepare for your sister’s illness?”
4. “If your dad were to quit drinking, what would your sister think?”

(3) Option 3 has all the criteria established asked in the question. There is a third person who is asked what behavioral changes they could make in relation to another family member’s condition. This is a nursing intervention using a triadic question within the behavioral domain of family functioning with the goal of changing the relationship between two other family members. Option 1 is a behavioral question but asks for facts and does not require investment of the third person. Option 2 is a triadic question but within the affective domain. Option 4 is a triadic question but within the cognitive domain.

**211.** When the nurse has as a treatment goal to change how a particular family perceives or believes in regard to its health problem, which of the following intervention strategies would the nurse use?

1. reframing
2. validating emotional responses
3. encouraging respite
4. devising rituals

(1) Reframing changes the emotional viewpoint in which a situation is experienced and places it in another concrete situation in which it fits equally well, thereby changing the meaning. Reframing can be used to make changes in cognitive family functioning. Validating emotional responses is a nursing intervention for the affective domain of family functioning and has as a goal to reduce or increase intense emotions that may be blocking families’ problem-solving efforts. Encouraging respite and devising rituals are both nursing interventions used to change the behavioral domain of family functioning with a goal of assisting family members to behave differently in relation to one another.



**212.** Which of the following statements by the nurse is consistent with changing the cognitive domain of family functioning by externalizing the problem?

1. "It is common for siblings of a terminally ill child to experience physical symptoms themselves."
2. "It must seem like the seizures your wife has take control of your lives."
3. "Let me show you how to do a search in the library about your illness so you can find out information for yourself."
4. "You have done a very good job of taking care of your child."

(2) In statement 2, the nurse has externalized the problem by referring to the seizures as having control of the situation versus the wife or husband. It helps the couple identify how much of their lives are controlled by her seizures. Statement 1 is also a statement that can effect change in the cognitive domain, but the strategy used by the nurse in this statement is offering education. By letting the family know that it is normal for a child to experience the symptoms it can assist the family in understanding and coping with them. Statement 3 is also a cognitive intervention but uses offering information as the tool. In this example, the nurse is even empowering the family to gain information for themselves. Statement 4 uses the strategy of commending family and/or individual strengths. It is also a strategy used to effect change in the cognitive domain. By commending the family, it enables them to have a positive view of themselves and creates a context for change in allowing them to believe they can discover some solutions to their problems.

**213.** When the nurse says to a family, "Tell me about your illness and how it has impacted your family," the affective domain of family functioning is changed by using which of the following interventions?

1. validating/normalizing emotional responses
2. storying the illness experience
3. drawing forth family support
4. reframing

(2) Most of the time families are encouraged to share the facts about their illnesses or family members. Directed questions are asked that elucidate the symptoms, medications, and treatments but ignore the families' experience of the illness. The statement contained in the question allows the family members to express fear, anger, or sadness about their illness experience. When the nurse validates emotional responses it reassures and offers hope to families that they can adjust and learn to cope. An example of a statement that validates is "It must be very frightening to have your mother diagnosed with cancer." Drawing forth family support refers to the process the nurse uses to assist family members in listening to each others concerns and feelings. It is used for the affective domain. An example of a statement that draws forth family support is "Why don't you tell your dad how it makes you feel to see your Mom suffer." Reframing is a strategy that changes the cognitive domain of family functioning.

**214.** All of the following interventions can be used by the nurse to change the behavioral domain of family functioning except?

1. offering education
2. encouraging family members to be caregivers
3. encourage respite
4. devising rituals

(1) Offering education is a nursing intervention to change the cognitive domain of family functioning by teaching about normal physiology, emotional and cognitive characteristic,s as well as developmental issues that can be affected by illness. Options 2, 3, and 4 are interventions the nurse can use to change the behavioral domain of family functioning. Behavioral changes result in family members behaving differently in relation to one another. Many family members will not have the courage or confidence to become involved in the care of their loved one unless encouraged to do so by the nurse. Usually family members come away from this experience very appreciative that the nurse assisted them in this matter. The need for respite varies from family to family but timeouts or time away is essential for families that are experiencing excessive caretaking demands. Rituals are important to families but may either be forgotten or not observed in times of illness or great stress. The nurse can help families devise new rituals that even experiment with care issues at hand and can bring great clarity to a confused situation.

**215.** Which of the following characteristics of a family must be present in order to substantiate a nursing diagnosis of interrupted family processes?

1. Family system does not meet the physical needs of all its members.
2. Family system does not express or accept a wide range of feelings.
3. Family system does not seek or accept help appropriately.
4. Family system does not adapt constructively to crisis.

(4) There are two major defining characteristics for the nursing diagnosis of interrupted family processes. Option 4 is one. The other is that the family system cannot communicate openly and effectively. Options 1, 2, and 3 are minor defining characteristics of the diagnosis. Major defining characteristics must be present in order to substantiate the nursing diagnosis. Minor defining characteristics may be present but are not required to substantiate the diagnosis.

**216.** Which of the following is a situational related factor to the nursing diagnosis of interrupted family processes?

1. disruption of family routines because of time-consuming treatments
2. change in the family member's ability to function
3. loss of family member by incarceration
4. financial burden of treatments for ill family member

(3) Being incarcerated is a situation that directly creates a loss of the family member and causes interrupted family processes. It is a situational related factor. Disruption of family routines because of treatments is a treatment related factor. A change in the family member's ability to function is a pathophysiologic related factor. The financial burden of treatments is a treatment related factor.

**217.** Which of these factors, if identified in the history of a family, is most likely related to the development of a crisis leading to interrupted family processes?

1. apathy
2. unstable work history
3. frequent relocations
4. participation in religious activity

(4) Participation in religious and community activities provide families with coping skills and support networks and lessen the probability of crisis. Characteristics of families prone to crisis include those listed in options 1, 2, and 3 as well as poor self-concept, low income, inability to manage money, unrealistic preferences, lack of skills and education, history of repeated inadequate problem solving, lack of adequate role models, and environmental isolation.

**218.** Which of the following characteristics, if identified in a Vietnamese family, would indicate to the nurse the family is at risk for interrupted family processes?

1. A family member is admitted to a hospital for psychiatric care.
2. A family member has been fired from their job.
3. A family member has broken one of the Ten Commandments.
4. A family member has disobeyed a deceased parent's wishes.

(4) In the Vietnamese culture, family loyalty is "filial piety," which means that children are commanded to obey and honor their parents even after they have died. To disobey a deceased parent's wishes would put the family at risk for interrupted family processes. Option 1 would place an Arab American family at risk for interrupted family processes. Option 2 would place a Japanese American family at risk as that culture believes failure or achievement of one member reflects on the entire family. The Vietnamese culture also places high priority on individual behavior as it impacts the entire family, but of the options listed, option 4 would be the most likely to cause interrupted family processes in this culture. The Ten Commandments dictate the expected behavior of Jewish families toward their parents and within the community. To go against the commandments could cause interrupted family processes.

**219.** Which of the following characteristics must be present for a client who has a nursing diagnosis of parental role conflict?

1. Parent expresses feelings of inadequacy.
2. Demonstrated disruption in care and/or caretaking routines. Parent demonstrates disruption in care and/or caretaking routines
3. Parent expresses guilt about contributing to child's illness.
4. Parent verbalizes feelings of anger and frustration.

(2) There are two defining characteristics of the nursing diagnosis of parental role conflict. Option 2 is one. The other is Parent expresses concerns about changes in parental role. One or more of the major defining characteristics must be present to substantiate the diagnosis of parental role conflict. Options 1, 2, 3 and 4 are minor defining characteristics of the diagnosis and may be present but are not required to be present in order to substantiate the diagnosis.

**220.** Which of these measures, if included in the care plan for a family with twins, would be most effective to promote individuation of the twins?

1. Dress the children alike.
2. Take photographs with both twins in them.
3. Take each child on short separate outings.
4. Select names that sound alike.

(3) To promote each twin as an individual, each child should be taken on short separate outings while the other child stays at home with a parent or sitter. Other measures include: using their given names and not referring to them as the twins, providing separate rooms if possible, disciplining them individually, and providing toys per individual preference. Option 1 is wrong because that measure actually promotes the ideas of twins. To promote individuation, parents should avoid dressing them alike. Option 2 is wrong because to promote individuation each twin should have their own photographs, beginning from the time they are born. Option 4 is wrong because as tempting and cute as it is, alike sounding names does not promote individuation, but the concept of a pair/twins.

**221.** When a parent describes their philosophy of parenting as an atmosphere in which parental control is firm and consistent but tempered with encouragement and understanding, with control focused on the issue not the fear of punishment, the nurse should recognize this as indicative of which of the following parental styles?

1. authoritarian
2. authoritative
3. permissive
4. laissez-faire

(2) The authoritative or democratic style of parenting is described in the question. Parents with this style tend to combine attributes of other styles of parenting without extremes. They emphasize the reason for rules and respect the individuality of each of their children. This style of parenting fosters a consciousness that regulates behavior. Authoritarian parenting is characterized by parents trying to control their children's behavior and attitudes through unquestioned mandates. Behavior that is against the parental standards is punished with little explanation. Permissive and laissez-faire parenting are the same style of parenting. In these styles, parents attempt to have little control over their children's actions and avoid imposing their own standards of conduct on their children. Discipline is lax and inconsistent. In this style of parenting, the children control the parents and are often disobedient, disrespectful, irresponsible, aggressive, and generally defiant of authority.

**222.** When a parent says to the nurse, "I spank my child because nothing else works," the best first response by the nurse would be?

1. "Spanking should only be used as a last resort."
2. "Spanking teaches children that violence is acceptable."
3. "Tell me about how and when you spank your child."
4. "Let me tell you about another form of discipline called time-out."

(3) None of the responses are incorrect information or even a necessarily poor choice. The question asked for the BEST FIRST response. Assessment is always a good place to begin. When the nurse knows more about how and when the child is spanked, then the information she relays can be specific and individualized. That information may include options 1, 2, and 4. If parents insist on spanking their children, there is some guidance the nurse can give: use only as a last resort, never use in public, use only their hand, give one swat to the bottom followed by a stern message and/or additional consequences. If parents have ever hurt their child when spanking them, they should never use that form of discipline again.

**223.** When a parent reports that when their child misbehaves they use time-out, the nurse should recognize this as indicative of discipline with which type of consequences?

1. natural
2. logical
3. unrelated
4. behavior modification

(3) Unrelated consequences are those that are imposed deliberately. An example would be the use of time-out or no TV until chores are done. Natural consequences are those that occur without any intervention such as getting a failing grade for not doing homework or not going on a field trip because they were late and missed the bus. Logical consequences are those that are directly related to the rule, such as not being allowed to play with a toy until the others are put up. Behavior modification is not a part of discipline by consequences but is characterized by rewarding desired behavior. Many times once the reward is withdrawn, the undesired behavior returns.

**224.** When assessing a gay or lesbian family, a nurse would expect to identify which of these characteristics?

1. dysfunctional children
2. delayed gender identity
3. behavioral difficulties
4. biological child of one parent

(4) Most children in gay or lesbian households are the biological children of one of the parents from a previous marriage or the result of fertility assistance that enables procreation such as artificial insemination or the use of surrogate mother. Adoption or foster parenting, however, is an option for gay and lesbian families. There is extensive literature evaluating the parenting ability of gays and lesbians. Compared to heterosexual families, there is no increase in dysfunctional children, no difference in gender or sexual identity; no difference in gender role behaviors; no difference in adolescent sexual orientation; no difference in prevalence of behavioral, emotional, or psychiatric difficulties, personality characteristic, locus of control beliefs, moral maturity, or intelligence.

**225.** The teaching plan for gay or lesbian parents who want to disclose their homosexuality to their children should include all of these instructions except:

1. disclose the information before the child knows or suspects.
2. be comfortable with your sexual preference first.
3. have the discussion in a quiet place where interruptions are unlikely.
4. explain how your relationship with the child will change because of the discussion.

(4) Children of gay and lesbian parents should be reassured that their relationship with their parent will not change because of the discussion. Options 1, 2, and 3 are all important aspects of the disclosure. As children grow, they may have additional questions. Preschool children may not understand the absence of a father or mother. School-age children may be troubled that their family isn't like their friend's family. Adolescents may become reluctant to discuss it or accept it, even though they expressed acceptance at an earlier age. In general, the earlier children are informed, the easier it is for them to accept and assimilate the information. Nurses need to be nonjudgmental and learn how to express and accept these differences so they can keep the nurse-child-family relationship intact.

**226.** When a client describes their family as having multiple wives, all of whom are sisters, married to one man, the nurse documents the family structure as:

1. polyandry.
2. soronal.
3. nonsororal.
4. sororate.

(2) The practice of polygamy refers to having multiple wives or husbands. When there are multiple wives who are sisters, the polygamy is designated as soronal. When the wives are not sisters, it is nonsororal. Polyandry refers to multiple husbands and is rare. Some cultures practice a polygamy designated as sororate. Sororate polygamy specifies that a husband must marry his wife's sister if she dies. These marriages are successive rather than concurrent.

**227.** A nurse observes a client sitting alone and talking. When asked, the client reports he is talking to the voices. The nurse's next action would be:

1. touch the client to help return to reality.
2. leave the client alone until reality returns.
3. ask the client to describe what is happening.
4. tell the client there are no voices.

(3) Nurses frequently observe behavioral cues that indicate the presence of hallucinations. Talking about the hallucinations is reassuring and validating to the client. Focusing on the symptoms and asking about the hallucinations empowers the client to gain control.

**228.** A client in an acute care psychiatric hospital asks, "Who are those two people by the door?" The nurse recognizes the client is having a hallucination, and the best response would be:

1. "I do not see anyone. Can you tell me more about what you are seeing?"
2. "There is no one there. You are seeing things again."
3. "Just ignore them. They will go away."
4. "I told you before there is no one there. Why do you keep bothering me?"

(1) Nurses need to inform clients that there is a difference in perceptions and pay attention to the content of the hallucination. Nurses need to determine whether a command hallucination is occurring that tells the client to harm himself or others. When the client is able, an appropriate intervention is to assist the client to identify triggers for the hallucination.

**229.** A client with a diagnosis of schizophrenia has been released from an acute care setting. The client had a prolonged recovery from relapse. The parents discuss the situation with the nurse. "I do not understand what is going on. The hospital said she was better, but all she does is sit around all day and smoke. We cannot get her to go to the vocational training you arranged." The nurse recognizes more teaching is needed about:

1. the pathophysiology and acting out behaviors of schizophrenia.
2. support groups that can help the parents release their feelings of frustration.
3. the prolonged recovery time and depressive effects of medicines to prevent relapse.
4. motivational techniques that are effective in clients with schizophrenia.

(3) The nurse conducting discharge teaching must stress the lengthy recuperation process with emphasis on the sedative qualities of the medication used to prevent relapse. Support groups are useful to the caregivers. The emphasis on recuperation is to maintain nutrition and hygiene.

**230.** A nurse is teaching a group of clients with a diagnosis of schizophrenia who are nearing discharge from a residential care facility. An essential topic to include would be:

1. pathophysiology of the disease and expected symptoms.
2. how to recognize and manage symptoms of relapse.
3. need to take extra medication when feeling stressed.
4. contact with follow-up care daily.

(2) Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed and may proceed to becoming withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone that is trusted, avoid negative people, and decrease stimuli and stress.

**231.** The nurse observes a staff member not following the plan of care for a client with an antisocial personality disorder. The nurse would:

1. confront the staff member immediately and say “You know that is not the treatment plan.”
2. write an incident report so there is a “paper trail” of the staff’s failure to follow the planned program.
3. ask the staff member to talk in private and reinforce how antisocial clients try to divide staff.
4. bring up the incident during the weekly conference so this staff will not be assigned to work with antisocial persons again.

(3) It is essential that the treatment program be followed exactly for clients with antisocial personality disorder because they are very manipulative and will attempt to divide staff. However, confronting the staff member in front of the client will enhance the division of staff. Talking with the staff member in private will allow the person to develop skills to work with this client population.

**232.** A client diagnosed with a borderline personality disorder frequently attempts to burn herself. The best intervention to facilitate behavior change would be:

1. constantly observe the client to prevent self-harm.
2. enlist client in defining and describing harmful behaviors.
3. check on the client every 15 minutes to ensure she is not engaging in harmful behavior.
4. remove all items from the environment that the client could use to harm self.

(2) The challenge when intervening with clients who may harm themselves is to maintain client safety while facilitating behavior change. Enlisting the client to identify the triggers for self-harm will make the client an active participant in treatment. Nurses are less judgmental when they understand the source of the behavior and can be sensitive to client feelings.

**233.** A nurse is developing a treatment plan for a client with a diagnosis of antisocial personality disorder. Which of the following would be a good positive reinforcer of desired behavior?

1. Place the client in isolation when undesirable behavior occurs.
2. Have the client save tokens for an outing once a month.
3. Accumulate points for daily trip to canteen.
4. Praise the client for desired behavior.

(3) Reinforcers for clients with antisocial behavior disorder need to be concrete and readily available. This group of client’s required immediate gratification; therefore, accumulated points need short-term rewards. Removing the client from contact with others may be necessary when the client cannot control behavior.

**234.** Which of the following statements indicates that a client diagnosed with antisocial personality disorder is meeting a desired short-term outcome?

1. Client describes interpersonal strengths and weaknesses.
2. Client does not manipulate other residents into giving him their belongings.
3. Client participates in a mutually satisfying interpersonal relationship.
4. Client uses interpersonal relationships as alternative to self-mutilation.

(2) Goals for clients with antisocial personality disorder include developing close interpersonal relationships and tolerating distress. A short-term objective would be to not engage in manipulation of other residents.

**235.** A family member of a client in the emergency department is pacing the floor. The family member stops between the nurse and the door and loudly states “You said the doctor would see my sister soon. We have been waiting for four hours. We want to see the doctor now.” The nurse believes the family member is becoming aggressive and says:

1. “You are next in line. The doctor will see you in 5 minutes. That is not too long.”
2. “There are sick people here. You need to calm down, or I will call security.”
3. “I know how you feel. Doctors always make you wait, even when you have an appointment.”
4. “I am sorry you have had to wait. It must be difficult to see your sister in pain.”

(4) When communicating with someone who is becoming aggressive, the nurse should remain calm and speak in a soft, nonprovocative manner. The most important intervention is to listen to the person. The nurse can apologize for delays and problems with the system. Threatening the person or making promises you cannot keep will escalate the anger.

**236.** A client is admitted to an acute care unit with a diagnosis of bipolar disorder. In past admissions, the client had assaulted others when stressed. To provide the client some control, during the admission assessment the nurse would:

1. instruct the client that he would receive one token per hour he was not aggressive.
2. ask the client what methods worked in the past to decrease aggressive behavior.
3. inform the client when agitated that the client would be taken to the gym to work off energy.
4. place the client in isolation until it was determined whether he was aggressive.

(2) Involving the client in identification of triggers and methods to decrease agitation and aggression empowers the client. For some clients, exercise decreases agitation; for others, exercise increases it. Token programs may be effective if the reward is something the client is willing to work toward. Unless the client is aggressive at time of admission, he should not be placed in isolation.

**237.** A nurse is developing a contract with a client with anorexia nervosa. A realistic goal for the first 2 weeks would be:

1. the client will not lose any weight for the first 2 weeks.
2. the client will gain 2 pounds each week.
3. the client will attain a realistic view of her body.
4. the client will identify irrational thoughts about her weight.

(1) A realistic initial goal for a client with anorexia nervosa is to refrain from activities that cause weight loss: bingeing, purging, laxative use, and exercise. Long-term goals include identifying triggers for the eating, purging, and exercising behaviors; recognizing faulty thinking; and acquiring adaptive coping responses.

**238.** A nurse is caring for a child in his home. The grandfather attempts to kiss the nurse. The nurse's best response would be to:

1. angrily state, "Stop that! You are a dirty old man. Don't come near me again."
2. laughingly say, "That is not what I am here for. You need to leave the room until you can behave yourself."
3. jokingly say, "Ooh, that's a no-no. Be careful, or I'll have to report you."
4. firmly state, "I am uncomfortable when you try to kiss me. Please do not do that again."

(4) Nurses are taught to be accepting of clients' behavior; however, when that behavior violates nurses' rights, limits must be set. Clients and their families do not have the right to be verbally offensive or to touch nurses' bodies without permission.

**239.** A client states, "I wish my wife were more like you. You are considerate and care about me. My wife is a grouch sometimes. She does not have time to give me any attention." The nurse would respond by:

1. informing the client that he is being inappropriate and is making her uncomfortable
2. telling the client he is transferring his emotions to her, and as he gets better he will stop feeling this way
3. helping the client realize the nurse provides care that his wife cannot; he has a more equal relationship with his wife.
4. advising the client that he needs to focus on ways to show his wife he cares for her.

(3) Clients may have difficulty differentiating between professional and social relationships. The nurse-client relationship is often idealized for the client. The client receives all the attention and caring and is not expected to give anything in return.

**240.** A client with a diagnosis of depression says that he wants to start taking herbs to help his condition. The nurse informs the client that the herbal product he wants to take is contraindicated while taking his medication and that:

1. he should stop taking the medication.
2. regular exercise will elevate his mood.
3. he should drink more coffee to give him energy.
4. the herbal product will make his medicine work better.

(2) Clients with depression may be taught self-care methods to help elevate their mood and prevent stress. Regular exercise has been found to elevate mood and relieve some symptoms of depression. Simple activities such as visits with family or friends, shopping trips, or going to the movies can provide pleasant diversions from daily routines and help relieve some of the symptoms of depression. Setting a schedule and following a sleep routine can help clients feel better and more rested. Hygiene is important as clients are less likely to isolate themselves if they feel good about their appearance.

**241.** A nurse is providing discharge instructions to a client who has received daycare treatment for extreme anxiety. The nurse will include which instruction for the client to use whenever anxiety is felt?

1. Begin an exercise program to work off excess energy.
2. Practice deep muscle relaxation daily.
3. Avoid negative people because they will increase your stress.
4. Find a job that is gratifying to increase your self-esteem.

(2) Behavioral techniques can be used to modify responses to anxiety-producing stimuli. The client should select a technique and practice it daily. Relaxation techniques can help control anxiety and may be used when anticipating situations that have produced anxiety in the past.



**242.** Which of the following nursing interventions is associated with lifestyle changes for the client with HIV infection?

1. providing detailed information about the pathophysiology of HIV transmission
2. reviewing numerous drug treatment options including side effects, contraindications, and drug to drug interactions
3. confidentially and kindly informing the client of his/her HIV status
4. critiquing the client's current "at risk" behaviors such as needle-sharing and unprotected sex

(3) HIV infected persons may curtail at-risk behavior and reduce the risk of transmission of the virus to others upon learning their HIV status; therefore, an effective way to reduce new cases is to increase infected persons' awareness of their HIV status. Detailed information about the pathophysiology and current pharmacologic agents would not be helpful to most clients nor promote lifestyle change. Simply reviewing the "at risk" behaviors may enlighten the nurse toward better understanding the client's lifestyle but offers no support for change.

**243.** In a primary care or out-client setting, which of the following client care strategies are encouraged to reduce new cases of HIV infection?

1. routine testing of all new clients
2. risk-screening of all clients at each visit
3. HIV counseling for all new clients
4. offering HIV prophylaxis to at risk clients

(2) According to CDC and other sources, the most effective way to reduce new cases is to increase infected persons' awareness of their HIV status. Routine testing of all new clients would not be cost effective and would be labor intensive. Risk screening is indicated on all new clients, but not at each visit. HIV counseling is indicated at key times when client and nurse deem it helpful or necessary (for example, prior to obtaining HIV testing).

**244.** Which of the following statements about client education is correct?

1. Face to face interaction is essential to achieve adherence.
2. The nurse must acquire appropriate credentials to teach the subject matter.
3. The interaction should include a summary of the disease process, review of the treatment plan, and questions/answers regarding what to expect if the treatment plan does not work.
4. Linguistic, cultural, and literary needs must be addressed.

(4) Although all of the preceding may improve the effectiveness of client education, addressing the uniqueness of the individual (that is, reading ability, health beliefs, cultural and language needs) is the only essential requirement upon which education must be based.

**245.** When assisting a client to achieve behavioral change, which of the following strategies is indicated?

1. overlooking minor infractions like failure to attend to group
2. withholding telephone privileges for failure to attend group
3. establishing a contract with the client that includes rewards and losses based on the behavior exhibited
4. allowing the client to express their feelings as needed

(3) Behavioral strategies are most effective when they reinforce positive behavior and decrease maladaptive behavior. Failure to identify, confront, and respond to behavior may indirectly reinforce negative outcomes. Clients can be expected to adhere to established patterns of conduct. Manipulative, inappropriate behavior should be diminished via withholding privileges including responses from others.

**246.** Which of the following behavioral theorists developed therapies to reinforce positive behavior and decrease negative by focusing on the effect of behavior and not its cause?

1. Erik Erikson
2. Maslow
3. B. F. Skinner
4. Carol Gilligan

(3) Skinner developed the technique known as operant conditioning as a means of modifying undesirable behavior to desirable by focusing on the manifestation of behavior and not the intrinsic root cause. Erik Erikson's work focused on developmental life stages and critical tasks. Maslow's work focused on the need hierarchy while Carol Gilligan's work looks at moral decision-making.

**247.** A client activates his call light every 10–15 minutes for items such as adjusting the bed, looking for a misplaced card, adjusting the window blinds, and so on. Before determining the client's behavior is inappropriate, which of the following nursing interventions should occur?

1. Explain to the client guidelines for using the call light.
2. Assess the client for psychological and physical discomfort.
3. Tell the client that you will check on him every 30 minutes without him calling.
4. Assist the client to identify areas where he can make choices.

(2) Assessment is the foundational step to identifying psychological and physical needs and identifying problems. Data gained from an accurate assessment will guide the nurse and client toward constructing a treatment plan. Depending on the data obtained from the assessment, nursing interventions may include education, comfort measures, analgesic interventions, diversional and/or psychological stimulation as well as many others.

**248.** When the nurse praises the client for remaining nicotine free for the past seven days, she is demonstrating which technique?

1. rational-emotive
2. positive reinforcement
3. conditioning
4. negative reinforcement

(2) Behavioral strategies are most effective when they reinforce positive behavior. Praising the client for his smoking cessation provides a reward for positive behavioral change and may serve to further strengthen his resolve to remain nicotine free.

**249.** A 10-month-old child is brought to the emergency department due to difficulty to awaken. The nurse notes bruises on both upper arms. This finding is most consistent with:

1. wearing clothing that is too small for the child.
2. being grasped tightly by both upper arms.
3. falling while learning to walk.
4. parents trying to awaken the child.

(2) Children who are shaken are frequently grasped by both upper arms. Infants who are shaken may have fractured ribs where they have been grasped tightly. Diagnosis of shaken baby syndrome is based upon findings of retinal hemorrhages, subdural hematoma, and increased head size from accumulation of fluid in the brain. Subtle symptoms include a history of poor feeding, vomiting, or flu-like symptoms with no accompanying fever or diarrhea, lethargy and irritability over a period of time.

**250.** A healthcare worker is concerned about a new mother being overwhelmed by her new infant. The healthcare worker would:

1. immediately contact child protective services.
2. provide the mother with literature about child care.
3. consult a therapist to help the mother work out her fears.
4. refer the mother to parenting classes.

(4) Prevention of child abuse is centered on teaching the parents how to care for the child and cope with the demands. Parenting classes can help build their self-confidence, self-esteem, and coping skills. Parents benefit by understanding the developmental needs of their children, while learning how to manage their home environment more effectively. The classes also increase the parent's social contacts and teach about community resources.

**251.** An 8-year-old Asian child is being examined during a school screening. The nurse notices small bruises on the anterior and posterior ribs and asks the child:

1. whether the family practices coining.
2. who hit the child.
3. whether the child has fallen.
4. how long the abuse has been occurring.

(1) The nurse must be aware of cultural practices that resemble child abuse. These practices include coining, cupping, and fallen fontanella. Coining and cupping are thought to draw infections from the body. Coining involves rubbing a heated coin on the chest and torso and may cause bruising. Cupping uses heated glasses, which may produce erythematous and ecchymotic rounded lesions or linear streaks on the body from the suction. Fallen fontanella involves turning a child upside down to correct a depressed fontanelle and can cause vomiting, diarrhea, and dehydration in infants. Retinal hemorrhages can also occur, and sometimes shaken-baby syndrome is erroneously diagnosed.

**252.** Incidences of child abuse appear to be higher in the African American community and may be explained by:

1. the increased number of African Americans viewing violence on television.
2. more single-parent households in African American communities.
3. stricter child-rearing practices in African American households.
4. a higher occurrence of rage in African Americans.

(2) Child abuse is higher in households with lower socioeconomic status and single parents. The increased incidence may be due to increased stress and fewer support systems.

**253.** The highest incident of child abuse occurs in children:

1. birth–3 years.
2. 4–6 years.
3. 6–10 years.
4. over 10 years old.

(1) Children ages birth to 3 years had the highest rates of victimization at 16.0 per 1,000 children. Girls were slightly more likely to be victims than boys. American Indian or Alaska Native and African American children had the highest rates of victimization when compared to their national population.

**254.** An adult who had been abused as a child is discussing the group therapy program. Which statement indicates the client has gained insight?

1. "I think I was a lonely child because I could not tell anyone about my abuse."
2. "I am now aware of how deep seated my anger is. Before, I did not realize I was angry."
3. "The program has given me the courage to tell my mother how I felt about her role in my hurt."
4. "There are so many people just like me, who are just normal people that had bad things happen to them."

(2) Children who are abused learn to cope with the painful experiences by ignoring painful feelings and avoiding getting close to people. As adults they usually continue to repress feelings, avoid close interpersonal relationships and frequently use alcohol or drugs to block painful memories. Long-term effects in adults may include criminal/violent behavior (for adult males), substance abuse, and a variety of social and emotional problems, including suicidal thoughts, anxiety, hostility, dissociation, and interpersonal difficulties.

**255.** A nurse is discussing the cultural influence on child abuse with a Latino client. Which statement would the nurse include?

1. In Latino cultures, there is a high incidence of talking about private family affairs.
2. Factors such as racism and discrimination impede ethnic minority clients from seeking assistance.
3. It is rare for cultural practices such as coining and cupping to be mistaken for child abuse.
4. Cultural sexual taboos about purity are not a barrier to disclosing incidences of child abuse.

(4) Although there has been improvement, children from minority cultures often receive less comprehensive service. Research indicates underutilization of supportive child welfare services and an overuse of substitute services, such as foster care. Good child welfare practice requires assessing the functioning of the family and its members within the social context, including economic, educational, social, political, and legal factors that affect the family's ability to function effectively.

**256.** A teacher consults a school nurse about a change in one of the student's behavior. The teacher reports that the student has suddenly developed poor grades, displays anxiety, and has made self-deprecating remarks. Both the nurse and teacher consider the possibility that child abuse may be the cause based on the knowledge that:

1. the incidence of child abuse is declining.
2. child abuse often causes cognitive and behavioral problems.
3. it is unusual for children to suddenly do poorly in school.
4. children do not make self-deprecating remarks unless victims of abuse.

(2) Abused children often exhibit a number of cognitive difficulties, including deficits in verbal, reading, math, and perceptual-motor skills; poor school achievement; and impaired memory. Behavioral problems, such as aggression, noncompliance, and antisocial behaviors, have also been associated with abuse, as have a variety of emotional difficulties, including depression, low self-esteem, and increased daily stress.

**257.** A parent asks about the possible consequences if child abuse is suspected. The nurse's best response would be:

1. "All reported cases result in the child being removed from the home, at least temporarily."
2. "The child welfare agency will investigate all reports."
3. "The child will be removed from the home during the investigation."
4. "The investigator's primary purpose is to determine whether abuse or neglect has occurred and whether there is a risk of it occurring again."

(4) Reports of suspected child abuse or neglect are received by child protection services. The report is screened to determine whether enough information is present to warrant an investigation. Investigators will talk to parents, other people in contact with the child, and the child if old enough. Children who are believed to be in immediate danger may be moved to a shelter, foster care placement, or a relative's home during the investigation and while court proceedings are pending.

**258.** A nurse is examining a child with a bite mark. The parent reports the family dog bit the child. The nurse questions the parent's explanation because:

1. the child has no other injuries.
2. the distance between the mark of canine teeth is greater than 3 centimeters.
3. the parent brought the child to receive care immediately.
4. the wound does not have puncture marks.

(2) A 3-centimeter distance between canine maxillary tooth marks indicates the bite probably came from a human. Dogs mouths are narrower than humans.

**259.** In cases of nonsexual child abuse, the offender is usually:

1. a parent.
2. a grandparent.
3. a neighbor.
4. a stranger.

(1) Although anyone can abuse a child, the most common perpetrator of child abuse is a family member. Males are more common as abusers than females.

**260.** What is the leading cause of death in infants and young children suspected of being physical abused?

1. kidney failure
2. respiratory failure
3. head trauma
4. sleep apnea

(3) Head injury is the leading cause of death among abused children under age 2 years. Head injuries, such as scalp swelling, skull fractures, and more serious intracranial injuries, are often missed by routine physical, neurological, and ophthalmologic exams and skeletal surveys. Children who have any of the following “high-risk” characteristics or injuries need intensive screening for asymptomatic head injury: age less than 6 months for any abusive injury, rib fractures, more than one fracture of any type, or facial injury.

**261.** The nurse is assessing for suspected child abuse. What is the advantage of interviewing the child and parent together?

1. The parent can answer any questions the child does not feel comfortable answering.
2. The parent can explain any questions the child does not understand.
3. The nurse can observe the interactions between parent and child.
4. The nurse can determine whether the stories match.

(3) The child and parent should be interviewed separately and together. The child may not feel comfortable answering the interviewer’s questions while the parent is present. Having the child and parent together allows the nurse to observe the dynamics between the two.

**262.** What information is most necessary to obtain during the initial assessment in potential child abuse cases?

1. a genogram showing the family relationships
2. patterns of discipline, nutrition, and sleep
3. an analysis of psychodynamic conflicts
4. reason for the visit and child’s physical health

(4) The physical health assessment is essential to obtain to determine that the child is not injured. The other items are important but not the initial priority.

**263.** Which activity will be included in a primary prevention strategy for child abuse?

1. long-term psychodynamic therapy
2. family therapy
3. supervised visits by parents
4. parenting classes for new mothers

(4) Primary prevention focuses on preventing the problem before it occurs. Secondary prevention focuses upon preventing a recurrence. Therefore, primary prevention includes classes on parenting, child development, and discipline.

**264.** A three year old is brought to the emergency room for vaginal discharge. Upon assessment, the nurse notes the child is cooperative, uninhibited with the exam, presents with enlarged vaginal and rectal orifices, multiple bruising of the perineum and has purulent yellow discharge on her panties. Further inspection reveals multiple scratches and bruises in various stages of healing and unusual round open lesions that are suspicious for cigarette burns. The doctor diagnoses urinary tract infection and orders an antibiotic. The nurse should:

1. call another physician to examine the child.
2. document the findings, inform the physician, and report the incident to authorities.
3. call security personnel and have the child removed from the caregiver immediately.
4. confront the caregiver and have her/him arrested.

(2) An interdisciplinary approach is best in management of pediatric abuse. The doctor's failure to recognize the signs/symptoms of abuse must be questioned. However, the child's safety requires outside evaluation and probable removal from the present environment. Local civil authorities (police, child protective agencies, and so on) will assist the nurse in ensuring the child is protected from further physical harm. In a situation as described, the nurse may want to elicit the support and assistance of the department's or hospital supervisor. The suspicion of abuse is a reportable incident by law, and the nurse is mandated to comply.

**265.** The nurse assesses for which of the following mental disorders in a child who has experienced abuse?

1. schizophrenia
2. bipolar disorder
3. paranoia
4. post-traumatic stress disorder

(4) Post traumatic stress disorder often follows exposure to a traumatic event involving the threat or belief of threatened death or serious injury to self or someone close to the person (sibling, parent). Schizophrenia and bipolar disorder have a strong genetic component, although stressful events may exacerbate these conditions. Paranoia, delusional thoughts of persecution, often accompanies disorders such as schizophrenia.

**266.** Which of the following interventions is most likely to enhance the community's response to sexual trauma?

1. increasing the police force
2. providing post trauma counseling free of charge
3. establishing a sexual assault nurse examiner program
4. providing emergency room care by board certified gynecologists

(3) Results from offices of justice and victims of crime have documented the effectiveness of sexual assault nurse examiner programs (SANE) and the improvement of community response they engender. Providing social support such as adequate police officers and post trauma counseling are also helpful. There is no documented benefit of specialized gynecology care over the SANE program. In fact, RN nurse examiners typically outperform medical doctors, including OB-GYN, in situations such as the treatment of rape.

**267.** A child states, "I have a problem, but you have to promise not to tell anyone." The nurse's best response would be:

1. "I can keep a secret. You can tell me."
2. "I will need to tell someone if you are being hurt."
3. "I will have to tell your parents anything that you tell me."
4. "Do not tell me anything you do not want others to know."

(2) Nurses are mandated to report suspicions and incidences of abuse. Ensuring the child's safety is a priority issue. It is important to let the child know at the outset that the nurse may be required to inform authorities. Failure to inform the child can result in loss of trust.

**268.** Child neglect is difficult to properly diagnose because:

1. specific standards of care are hard to understand.
2. cultural variations exist in attitudes about childrearing and discipline.
3. there is a direct relationship between poverty and neglect.
4. physical injuries caused by neglect are difficult to detect.

(2) Attitudes about childrearing have strong cultural influences. There are no specific standards about childrearing. Although poverty may mimic some of the signs of neglect, there is no direct relationship. Physical injuries are easier to detect than emotional injuries.

**269.** When assessing an injured child, the nurse recognizes which finding as an indicator of possible child abuse?

1. The parents delay seeking help after the injury occurred.
2. The mother states she had prenatal care for the entire pregnancy.
3. A sibling has a chronic debilitating illness.
4. The child is seen annually by the same healthcare provider.

(1) Delay in seeking medical treatment and inconsistent or extremely detailed history of how the injury occurred are "red flags" to indicate possible child abuse. Other factors include adolescent pregnancy, a history of family violence, and seeing many different healthcare providers.

**270.** Which of the following is a barrier to reporting suspected cases of child abuse or neglect?

1. The person reporting the case can be sued if the case is not proven.
2. It is ethically wrong to report if one is not positive abuse has occurred.
3. There is excessive paperwork involved.
4. Healthcare workers are concerned about confidentiality.

(4) The confidentiality of the person reporting the suspected abuse is protected. The person reporting the suspicion cannot be sued for slander or defamation of character if the report was made in good faith. A report of suspected child abuse can be looked upon as a request for the helping process to begin, rather than as an accusation.

**271.** An elderly client denies that abuse is occurring. The nurse recognizes which factor may be a barrier for the client admitting to being a victim?

1. knowledge that elder abuse is rare
2. personal belief that abuse is deserved
3. lack of developmentally appropriate screening tools
4. fear of reprisal or further violence if the incident is reported

(4) Barriers to reporting elder abuse include victim shame, fear of reprisals, fear of loss of caregiver, and lack of knowledge of agencies that provide services. Many elders fear that reporting abuse will result in their placement in long-term care because the current caregiver is the abuser.

**272.** The nurse observes bilateral bruises on the arms of an elderly client in a long-term care facility. The nurse would ask the client:

1. "How did you get those bruises?"
2. "Did someone grab you by your arms?"
3. "Do you fall often?"
4. "What did you bump against?"

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

**273.** A nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse's next action would be to:

1. do nothing; the client has the right to refuse treatment.
2. report the incident to the police.
3. arrange an appointment with the client's next of kin.
4. educate the client about available services.

(4) Although clients do have the right to refuse treatment the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.

**274.** When questioning an elder about suspected abuse, the nurse would keep the questions:

1. nonjudgmental.
2. probing.
3. confrontational.
4. indirect.

(1) Questions about suspected abuse should be direct and nonconfrontational. Indirect questions encourage denial.

**275.** The nurse is assessing an elder who the nurse suspects is being physically abused. The most important question for nurse to ask would be:

1. "How much money do you keep around the house?"
2. "Who provides your physical care?"
3. "How close does your nearest relative live?"
4. "What form of transportation do you use?"

(2) The most common abuser is a caregiver living with the client. Research reveals the spouse is currently the most common abuser, followed by an adult child.

**276.** A nurse notes that an elderly client suddenly does not keep appointments and is not wearing appropriate clothing. Which statement by the client would raise the suspicion of financial abuse?

1. "I am having difficulty paying for this new antibiotic the doctor prescribed."
2. "I am a little short on cash since my daughter moved in to help me."
3. "I have not felt like shopping since the weather has gotten worse."
4. "People do not realize how difficult it is to make ends meet on a fixed income."

(2) Elderly clients on fixed incomes have difficulty meeting new expenses, such as medicine. Signs of financial abuse include unexplained illness left untreated, inability to pay rent or purchase clothes and food, and inaccurate knowledge about finances. Financial abuse is a form of elder abuse and requires investigation.

**277.** Which activity would alert the nurse that an elderly client may be neglecting self-care?

1. Elder is alone during the day while adult child is at work.
2. Caregiver assists elder to toilet twice per day.
3. Elderly client does not buy medicine for serious illness.
4. Caregiver provides elder with food that the elder cannot chew.

(3) Elders can neglect themselves by not caring about their own health or safety. Elder self-neglect may lead to illness or injury. Signs of self-neglect are similar to neglect by others and include ignoring need for food and water, personal hygiene, adequate shelter, and medical attention for serious illnesses.



**278.** An elderly client reports that the caregiver does not allow the client to make phone calls or have visitors and reads the client's mail. The nurse suspects which type of abuse?

1. physical
2. emotional
3. neglect
4. financial

(2) Emotional neglect is a lack of basic emotional support, respect, and love. Activities that are included in emotional neglect include ignoring calls for help, inattention for client's need for affection, failure to provide necessary psychological care, and isolation from the outside world.

**279.** An elderly client who has been diagnosed with dementia for two years is diagnosed with severe pneumonia. The adult child reports the client has been ill for two weeks but refused medical care. The nurse would inform the adult child that since the elder has dementia, not seeking medical care appropriately could result in a charge of which type of elder abuse?

1. physical abuse
2. physical neglect
3. emotional neglect
4. financial abuse

(2) With both physical neglect and physical abuse, needs are not met. Physical abuse refers to inflicting harm upon the person, whereas physical neglect is failure to provide adequate care.

**280.** An elderly client states that she is concerned because she gets so angry with her husband who has developed dementia. She states, "Sometimes I feel like locking him in his room. He tries to wander outside all the time." The nurse's best response would be:

1. "Is there anyone who could give you a break every week?"
2. "That might work for short periods."
3. "You may want to try locking him in his room while you bathe."
4. "Have you tried this already?"

(1) Caregivers need to find ways to relieve the stresses of being totally responsible for the care of a dependent elder. Recommendations for respite include finding family or friends that can care for the person on a regular basis, referrals to respite care agencies, and finding adult day care programs. Caregivers resolve frustration or anxiety with abuse, neglect, or violence; need to learn other ways to cope. The caregiver may need to talk with someone or join a support group.

**281.** A nurse is talking with a woman whose husband has been diagnosed with Alzheimer's disease. The wife wants to care for her husband at home because he is less agitated there. She reports her husband becomes agitated when she is not around. The nurse would recommend:

1. "You are the person he is most comfortable around; therefore, you need to be within his sight at all times."
2. "You need to take care of yourself also, so get someone to give you a break on a regular basis."
3. "The doctor can prescribe some medicine to decrease his anxiety so that you can leave him alone for short periods."
4. "You need to place your husband in a nursing home so that someone can watch him at all times."

(2) Caregivers need to take care of themselves to prevent becoming frustrated and possibly abusing the elder. Self-care includes having respite periods, seeking medical care as needed, getting professional help for substance abuse or depression, and increasing the caregiver's support group.

**282.** An elderly client who is the victim of abuse and his family have been attending counseling sessions. Which statement made by the abuser indicates further teaching is needed?

1. “I did not understand before that my father needed extra time to do everything. I used to think he was slow just to annoy me.”
2. “I feel better able to care for my father now. I have this list of agencies that I can use to get help.”
3. “I will take a brisk walk whenever I feel frustrated with my father.”
4. “I am very ashamed that I hit my father. It will never happen again.”

(4) Abusers frequently make promises that might not be kept in the future. The other options show more understanding of the needs of the elder, available resources and coping methods.

**283.** An emergency department nurse is caring for an elderly client who is the victim of physical abuse. The nurse would select which as the priority nursing action?

1. maintaining the “chain of evidence” for all physical findings
2. ensuring the client is free from immediate danger
3. notifying the authorities of the client’s situation
4. referring the abuser to appropriate treatment

(2) Priority is based upon Maslow’s hierarchy of needs theory. Physiological needs are met first. If no physiological need is present, then safety is the priority.

**284.** A client who has been the victim of elder abuse has the nursing diagnosis of “ineffective individual coping.” Which is the least realistic short-term goal for the client?

1. Client will identify when stress occurs.
2. Client will develop adaptive coping strategies.
3. Client will express and share feelings.
4. Client will stop blaming himself for the abuse.

(3) The initial step is sharing feelings. Options 1, 2, and 3 show positive movement. Clients who have been abused frequently believe they are to blame for the abuse, and it may take a long time for this belief to change.

**285.** An elderly client is in the emergency department after physical abuse by a family member. The nurse would include which instructions prior to the client’s discharge?

1. how to leave a violent situation
2. available self-defense classes
3. how to complete the mandatory reporting forms
4. ways to avoid antagonizing the abuser

(1) The nurse should provide the client with methods to obtain help including a specific plan for leaving the house, hot-line numbers, and available shelters. An abused person is usually reluctant to notify the police, and the victim does not complete the mandatory reporting forms. Teaching the victim self-defense may result in more extensive injury.

**286.** How are models of child and elder abuse similar?

1. Both have specific outlined assessment procedures that help identify the perpetrator.
2. Both have mandatory statutes outlining who is required to report suspected abuse.
3. Both emerged from a published treatise about the battered syndrome.
4. Both advocate interventions that are rooted in Freudian and psychodynamic theory.

(2) Healthcare providers are mandated to report suspicions of abuse in children, elders, and dependent adults. No person required to report will be criminally liable for reporting suspected abuse, unless the person knows the report is false. The identity of the person reporting is kept confidential.

**287.** Why is it important for nurses to take into account culture, race, and ethnicity when assessing elder abuse?

1. Abuse is nonexistent in some cultures.
2. Culturally relevant services in family violence are ineffective.
3. Cultural norms affect how abuse is defined and whether the victim views himself as being abused.
4. Protective services require practitioners to be well versed in the cultural beliefs of all minority groups.

(3) Culture influences how abuse is manifested, perceived, and responded to. Cultural values, beliefs, and traditions significantly affect family life. They dictate family members' roles and responsibilities toward one another, how families cope with stress, and determines whether and when families will seek help from outsiders. Understanding these factors can significantly increase nurse's effectiveness. The nurse cannot be well versed in the all cultural beliefs. It is important to determine who is expected to care for the elderly and what happens when this person fails to do so. In some cultures, it is acceptable to use the elder's resources to help out other family members.

**288.** When caring for elderly clients from the African American culture, the nurse recognizes that in this culture:

1. elders tend to move to rural areas when they age.
2. children return to live with their parents during hard times.
3. the a long life expectancy puts a burden on the family.
4. children feel an obligation to support their elders.

(4) African American children expect to provide emotional and financial support for their elders. White caregivers report more depression and view care giving as stressful more often than African Americans. Minority groups may not have more available support than white caregivers. White elders appeared significantly more tolerant of verbal abuse than either of the other groups.

**289.** The daughter of an elderly woman refuses to leave the room while the client is being examined. This would alert the nurse because it may be a sign:

1. of financial difficulty and financial abuse.
2. of physical abuse that the perpetrator is hoping will not be detected.
3. the elder is having difficulty getting transportation, and social services needs to be notified.
4. the elder's social support network is weak, and the person needs more services.

(2) Like other forms of abuse, the perpetrator of elder abuse may not allow the client to be examined alone for fear the client will say something to indicate abuse is occurring.

**290.** The nurse is in a key position to combat elder abuse by:

1. providing constant intense monitoring of the frail elder.
2. expecting top identify abuse every time one cares for an elder.
3. recognizing that ignorance of the needs of elders is one of the reasons for abuse.
4. knowing elders with dementia are the only ones abused.

(3) Abuse or neglect may result from lack of knowledge of the needs of elders. Generally a combination of psychological, social, and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of elder maltreatment. Particularly in the case of adult children, abusers often are dependent on their victims for financial assistance, housing, and other forms of support. The nurse should consider the possibility that abuse may occur in any setting and economic level. Elders often do not report abuse because of shame and dependence on the abuser.

**291.** When assessing elderly clients, the nurse considers the possibility of abuse occurring especially in elders who:

1. are dependent and vulnerable.
2. have no living relative.
3. are women.
4. have incomes below the poverty level.

(1) Abusers of the elderly are usually relatives that may or may not live with the victim. Both elderly men and women are victims and abuse crosses all socioeconomic lines and cultures. The greatest risk is for the person to be dependent on the abuser.

**292.** A nurse suspects an elderly client has been abused. Which person is the most likely abuser?

1. adult child
2. neighbor
3. home health aide
4. distant relative

(1) Abusers of older adults are both women and men. Family members are more often the abusers than any other group. For several years, data showed that adult children were the most common abusers of family members; recent information indicates spouses are the most common perpetrators.

**293.** A 12-year-old male is brought to the primary care provider to determine whether sexual abuse has occurred. The mother states, “Since there is no permanent physical damage, he will not need any more treatment.” The nurse’s response would be based upon knowledge that:

1. male victims of sexual abuse seldom have long-term psychological problems.
2. survivors of male sexual abuse may become confused about question their sexual identity.
3. unless treated, all male sex abuse survivors grow up to abuse other children.
4. all children who have been sexually abused have the same needs, regardless of gender.

(2) Male children are sexually abused as much as, or almost as much as, female children. And women, as well as men, are perpetrators. Needs of male children who have been sexually abuse may be quite different from female survivors. Male survivors frequently respond in anger, question their sexuality, use alcohol and other drugs, and may try to prove their masculinity by performing daring acts.

**294.** A nurse is planning a brief treatment program for client who was raped. A realistic short-term goal would be to:

1. identify all psychosocial problems.
2. eliminate client’s enticing behaviors.
3. resolve feelings of trauma and fear.
4. verbalize feeling about the event.

(4) A brief treatment program is not designed to identify or resolve problems. Instead the focus is on managing acute symptoms. If in-depth psychological problems are identified, the nurse may make referrals for treatment. As a result of abuse, children, especially boys, tend to “act out” with behavior problems, such as cruelty to others and running away.

**295.** An adolescent female reports being raped at a party where alcohol was served. The client admits to drinking alcohol before being raped by an acquaintance. The nurse would:

1. inform the client that since she is underage, she is at fault for attending a party where alcohol was served.
2. ask the client whether anyone witnessed the event because the client was intoxicated and might not remember correctly.
3. inform the client that it was not her fault and support the client through the physical examination.
4. question whether the woman had consensual sex and now just feels guilty.

(3) Acquaintance rape remains a controversial topic because of lack of agreement upon the definition of consent. Most acquaintance rapes take place in either the victim's or the assailant's home or apartment. Most victims of acquaintance rape inform someone close to them, but less than 30 percent report the incidence to the authorities. Survivors of acquaintance rape report similar levels of depression, anxiety, complications in subsequent relationships, and difficulty attaining pre-rape levels of sexual satisfaction to what survivors of stranger rape report. Coping is more difficult for victims of acquaintance rape if others fail to recognize that the emotional impact is just as serious.

**296.** A client goes to the mental health center for difficulty concentrating, insomnia, nightmares, and reports to being raped as a child. The nurse will assess the client further for signs of:

1. general anxiety disorder.
2. schizophrenia.
3. post-traumatic stress disorder.
4. bipolar disorder.

(3) Childhood sexual abuse is associated with adult-onset depression, also with increased risk for lifetime and current post traumatic stress disorder (PTSD). About a third of all victims of sexual abuse meet the diagnostic criteria for PTSD. A person with PTSD has three main types of symptoms: Re-experiencing the traumatic event with flashbacks, nightmares, and exaggerated reactions to triggers that remind the person of the event. Emotional numbing evidenced by avoidance of activities, places, thoughts, feelings, or conversations related to the trauma; feeling detached from others and restricted or blunted emotions. Increased activity seen in bursts of anger, difficulty sleeping, hypervigilance, difficulty concentration, and exaggerated startle response. Other problems associated with PTSD are panic attacks, suicidal thoughts and feelings, substance abuse, eating disorders, feelings of alienation and isolation, and feelings of mistrust and betrayal.

**297.** During a well baby check of a 6-month-old infant the nurse notes abrasions and petechiae of the palate. The nurse would:

1. inquire about foods the child is eating.
2. ask about the possibility of sexual abuse.
3. request to see the type of bottle used for feedings.
4. question the parent about objects the child plays with.

(2) Generally oral sex leaves little physical evidence. Injury to the soft palate, such as bruising, abrasions, and petechiae, and pharyngeal gonorrhea are the only signs. Infants are at risk for sexual abuse.

**298.** A woman seeks assistance for recently remembering childhood sexual abuse. The nurse would include which goal?

1. prosecuting the perpetrator
2. managing symptoms of anxiety and fear
3. determining whether memories are real
4. corroborating the client's story

(2) At least 10 percent of victims of childhood sexual abuse will have periods of complete amnesia about the abuse, followed by delayed recall. There is evidence that people who have recovered memories have had part of those memories reconstructed by therapists. The nurse's role is not to determine whether the memories are true, but to help the client deal with the stress caused by the remembered abuse.

**299.** A mother reports that her child stated the father sexually abused her. When the mother expressed disbelief, the child recanted the story. The nurse would include which fact when talking with the mother?

1. The child made up the story as evidenced by later denying it.
2. The child should be punished for lying.
3. The child could be prosecuted for slander.
4. Children rarely lie about being sexually abused.

(4) Sexually abused children often recant disclosures and information when they feel that what they have said is not accepted or heard by significant adults. In particular, with incest cases, disbelief expressed by the nonoffending parent can feel like pressure to a child to recant their disclosure. Children may also recant disclosures when the perpetrator denies the disclosure; they are repeatedly questioned, or when disbelief is expressed by other significant adults, such as teachers or family members, such as siblings.

**300.** A teacher reports that a child has been sexually abused. When the child is brought for the physical exam, the mother states, “It is impossible. My husband has never been alone with my daughter. She must have heard about this from her friends.” The nurse’s best response would be:

1. “You must have suspected something. Your child could not be abused without you knowing.”
2. “The physical exam will prove whether sexual abuse has occurred.”
3. “Women often have difficulty believing a man they trust would hurt their child.”
4. “Denial is a common reaction, but you will soon be convinced.”

(3) The nonoffending parent initially may deny that the abuse could occur. The parent then may progress through the stages of grief. Some parents may never believe the child’s claim. If physical evidence exists, that information can be used to help convince the parent that the abuse did occur. However, before the evidence is collected, the nurse would help the parent express her feelings.

**301.** A client reports being sexually assaulted 48 hours ago. The nurse would recommend the client have a complete medical evaluation to:

1. gather data in case the client wishes to prosecute.
2. determine whether sexual abuse really occurred.
3. provide data for the medical team to identify the perpetrator.
4. perform tests for sexually transmitted diseases.

(4) After 48 hours, physical findings to identify whether sexual assault occurred and evidence to identify the perpetrator may not exist. The client would need a complete medical examination to determine the extent of injury and to test for sexually transmitted diseases, such as Chlamydia, syphilis, gonorrhea, trichomonas, hepatitis B and HIV. Pregnancy prevention should also be addressed.

**302.** A nurse is planning to begin a counseling program for women who have been sexually abused. The nurse decides to have at least one separate session for survivors who are adolescents to discuss which topic?

1. forced versus consensual sex
2. how to regain trust
3. managing anxiety symptoms
4. self-protection measures

(1) Adolescent victims may feel their actions contributed to the assault and have confusion as to whether the incident was forced or consensual. This is especially true if alcohol or other drugs was involved. Adolescents, like adults, may feel self-blame and humiliation that prevents them from seeking medical care. All rape victims need help with managing anxiety, regaining trust and feeling safe.

**303.** Tears and bruising are noted during a client’s annual gynecological examination. When asked how the injuries occurred, the client reported her husband. The nurse’s best response would be:

1. “Why did you let him do this to you?”
2. “Had he been drinking before the event?”
3. “Do you have any other injuries?”
4. “You need to file a report with the police.”

(3) Women who are involved in physically abusive relationships are vulnerable to rape by their partners. When marital rape is suspected, the nurse needs to assess the client for other injuries. The first option places the blame on the woman.

**304.** A nurse is caring for an elderly client in a long-term resident facility. While assisting the client with her bath, the nurse notices dried blood on the client's underwear. The nurse would:

1. rinse the underwear in cold water.
2. ask the client whether she is having her menstrual period.
3. ask the client whether anyone hurt her.
4. ask the client whether she has a boyfriend.

(3) An elder may not report an abusive sexual incident because of shame or fear of retaliation. Seniors who are suffering from dementia will not be capable of giving or withholding consent and may be unable to remember the unwelcome conduct. Physical signs of sexual abuse in an elder are the same as in younger women: torn or bloody clothing, unexplained sexually transmitted diseases or genital infection, and genital or anal pain, itching, bruising, or bleeding.

**305.** A nurse is working with a family in which one of the parents sexually abused a child. The desired outcome of the intervention would be:

1. that after the intervention the family will be intact.
2. the child is placed in foster care permanently.
3. the child is placed for adoption.
4. the nonoffending parent divorces the offender.

(1) The preferred outcome in cases of sexual abuse, as in other types of child maltreatment, is that after intervention the family will be intact. The victim may be removed if the mother is unable or unwilling to protect and support the victim or if the victim wishes to be removed. After these initial decisions, a longer term plan must be made about whether the child should be a part of the family and, if so, whether or not that family should include both parents. This plan will be based on an assessment of each parent. Aspects of the functioning of both should be examined in deciding about the child's future living situation.

**306.** A mother asks what treatment is best for her 5-year-old child who was sexually abused. The nurse's best response would be:

1. "Your child is strong and can deal with the event without any treatment."
2. "If you do not talk about the incidence, the child will forget it and be fine."
3. "You might look for a therapist who practices play therapy."
4. "It does not matter who you choose, just get her some help."

(3) Young children communicate more with play than with words, and thus, therapy with them will likely take a different form than therapy with older children and youth. With young children, therapy may take the form of symbolic play where the therapist is trained to interpret the child's responses through her actions.

**307.** The physician recommends a colposcopic examination for a woman who has been raped. The client asks the nurse what that means. The nurse would tell the client it:

1. is a procedure to cleanse the vagina to prevent pregnancy.
2. uses a camera to photograph injuries invisible to the naked eye.
3. is a method to collect semen to identify the perpetrator.
4. is a medication to promote healing of internal injuries.

(2) A colposcopic camera is a specialized unit for viewing or photographing abnormalities or injuries invisible to the naked eye. It is used to find subtle or invisible abnormalities or injuries to the vagina, cervix, or anus.

**308.** Teens who have been sexually abused are at higher risk for which of the following?

1. hypertension
2. eating disorders
3. obesity
4. acne

(2) Substance abuse, alcohol use, smoking, depression, and eating disorders are all more common in teenagers who have been sexually abused.

**309.** A 14-year-old female discloses to the school nurse that she fears she may be pregnant by her 22-year-old boyfriend. After obtaining a thorough assessment, what should the nurse do next?

1. Report the matter to the principal's office.
2. Report the matter to the parents.
3. Report the matter to the local police department.
4. Report the matter to the Child Protective Services department.

(4) In most states, statutory rape is defined as sexual intercourse with a minor under the age of 16 and is a reportable offense. While all of the other entities could debatably receive notification, it is mandatory that the girl is protected through reporting the situation to protective services.

**310.** A 3-year-old child is receiving an anal exam by the nurse who notes diastasis, anal fold thickening, enlarged orifice, and fecal soiled underpants. These findings are most consistent with:

1. pinworms
2. prolapse of anus
3. sexual abuse
4. self-mutilation

(3) The findings are highly suggestive of sexual abuse and must be reported. In addition, the nurse and interdisciplinary healthcare team must ensure the child's immediate safety. Pinworm infestation typically produces redness and local irritation while anal prolapse presents with the protrusion of the anal region in part or complete. Self-mutilation could be a possibility, but only after sexual abuse is ruled out.

**311.** The nurse suspects sexual abuse of a 3-year-old child. The intervention would include:

1. confronting the abuser.
2. only documenting the suspected case.
3. enabling the client to prevent further injuries.
4. notifying child protective services.

(4) The priority is to protect the child from further injury and notifying child protective services is mandatory in all states. Teaching the child how to prevent further injuries is impossible at this age and indicates the child may be responsible for what happened.

**312.** In 90 percent of child sexual abuse cases, the offender is:

1. a stranger.
2. a neighbor.
3. a male.
4. a female.

(3) The most common form of child sexual abuse is a man against a female child. Other forms of child sexual abuse include same-sex abuse, woman against male child, and older children against younger children.



**313.** When talking to a child who has been sexually abused, the nurse would be aware that perpetrators often use which rationale to justify child sexual abuse?

1. The adage children should be seen and not heard is widely accepted.
2. Discipline, even severe, is needed to eliminate the evil nature in children.
3. The child is a temptress, and the perpetrator cannot resist.
4. The family is a private arena and one can do whatever one pleases.

(3) Perpetrators of sexual child abuse frequently blame the child for seducing them. The other answers are reasons that all forms of child abuse are not reported.

**314.** A woman asks, "How much alcohol can I safely drink while pregnant?" The nurse's best response would be:

1. "No amount of alcohol is safe during pregnancy."
2. "Consuming one or two beers or glasses of wine a day is considered safe for a healthy pregnant woman."
3. "Drinking three or more drinks on any given occasion, bingeing, is the only harmful type of drinking during pregnancy."
4. "You can have a drink to help you relax and get to sleep at night."

(1) The best recommendation is that no alcohol be consumed during pregnancy. Fetal alcohol syndrome is a combination of mental and physical abnormalities present in infants born to mothers who have consumed alcohol during pregnancy. The amount of alcohol needed to cause fetal alcohol syndrome has not been determined.

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

1. the client's body has developed efficient enzyme systems to metabolize the medicine, requiring more drug to produce the same effect.
2. the client is preoccupied with getting the drug and has loss of control, indicating drug dependence.
3. addiction is the term used to describe the physical dependence with withdrawal symptoms and tolerance.
4. the client has a dual diagnosis of substance abuse and chronic back pain.

(1) Substance dependence is a severe condition indicating physical problems and disruption of the person's social, family, and work life. The psychological behaviors related to substance use are termed addiction. Dual diagnosis is the coexistence of substance abuse and psychiatric disorders.

**316.** When discussing the patterns of use of alcohol and other drugs, the nurse includes:

1. lifetime prevalence and intensity of alcohol use is greater in women than men.
2. Hispanics and African Americans have higher levels of alcohol use than Caucasians.
3. overuse of alcohol and other drugs increases into the mid-twenties, levels off, and decreases with age.
4. heavy use is more common in higher socioeconomic groups because they can afford to buy the drugs.

(3) Recent research reveals that 83 percent of all persons in the United States age 12 years or older reported using alcohol sometime in their lives. Use of alcohol and illicit drugs appears to increase into the mid-twenties, level off, and then decrease with age. Both lifetime prevalence and intensity of alcohol use are greater in males. Caucasians report higher levels of alcohol use than African Americans or Hispanics. Those with more education are more likely to use alcohol, but heavy use is more common among less educated and the unemployed.

**317.** A client is admitted with a diagnosis of multiple drug use. The nurse plans care base upon knowledge that:

1. multiple drug use is very uncommon.
2. people may use more than one drug to enhance the effect or relieve withdrawal symptoms.
3. alcohol and barbiturates used together are not dangerous because one is a stimulant and the other a depressant.
4. assessment and intervention are easier with multiple drug use because of the synergistic effect.

(2) Simultaneous or sequential use of more than one substance is very common. Multiple drug use may enhance, lessen, or change the nature of the intoxication or relieve withdrawal symptoms. Heroin users often also use alcohol, marijuana, or benzodiazepines. Multiple drug use is especially dangerous if synergistic drugs are combined. Multiple drug use complicates assessment and intervention because the client may be demonstrating effects or withdrawal from several drugs.

**318.** While admitting a client to an acute care psychiatric unit, the nurse asks about substance use based upon knowledge that:

1. in addicted populations, there is greater prevalence of psychiatric illness.
2. people with psychiatric disorders are more prone to substance abuse.
3. substance disorders are easily detected and diagnosed in acute care psychiatric settings.
4. undetected substance problems have no real effect on treatment of psychiatric disorders.

(2) The failure to address substance abuse among clients with psychiatric disorders interferes with treatment effectiveness and contributes to relapse. Misdiagnosis of psychiatric disorder, suboptimal pharmacological treatment, neglect of appropriate interventions, and an inappropriate referral may also occur.

**319.** When planning care of a client who has been diagnosed with amphetamine abuse, the nurse uses the knowledge that:

1. amphetamines increase energy by increasing dopamine levels at neural synapses.
2. amphetamines have low risk of tolerance or addiction.
3. amphetamines produce a 10–20 second rush followed by a 2–4 hour high.
4. addiction to barbiturates and amphetamines is rare because they have opposite effects.

(1) Amphetamines cause the release of norepinephrine and dopamine from storage vesicles into the synapse. The increased catecholamines at the receptors causes increased stimulation. Clear patterns of tolerance and withdrawal have not been described. Prolonged or excessive use of amphetamines can lead to psychosis. People use amphetamines for the feelings of euphoria, relief from fatigue, and energy and alertness. Overdose may cause seizures, cardiac arrhythmias, hypertension, and hyperthermia. When abstaining the client may experience fatigue, depression, and irritability lasting for several weeks. Drug cravings are common and may lead to relapse.

**320.** Methadone is used to aid withdrawal and provide maintenance for persons with opiate addiction because methadone:

1. replaces endorphins so craving is diminished.
2. produces dramatic negative symptoms if opiates are used.
3. enhances euphoria by increasing neurotransmitters of enkaphalens.
4. does not interfere with the ability to function productively.

(4) Maintenance programs for long-term opiate addiction may last for years using substitute narcotics. LAAM is a longer acting opiate antagonist. Methadone will produce addiction; however, the person remains productive.

**321.** Parents of a 14-year-old child who is being treated for marijuana use discuss the child's apathy and lack of desire to achieve. The nurse explains that:

1. this is typical teenage behavior and not related to the marijuana use.
2. prolonged marijuana use causes amotivational syndrome.
3. this behavior is a precursor to a psychotic stage.
4. the behavior is due to the physical dependence on the drug.

(2) People use marijuana for the effects of relaxation, mild euphoria, and reduced inhibitions. Undesirable effects of marijuana use include tachycardia and panic. Prolonged use has been associated with decreased motivation, poor hygiene, lack of energy, and loss of desire to be productive.

**322.** A client is admitted to an acute care psychiatric center for reported (PCP) intoxication. The nurse expects the client to:

1. be withdrawn.
2. have impulsive behavior.
3. be euphoric and happy.
4. have severe withdrawal symptoms.

(2) Phencyclidine (PCP) causes an anesthetic effect so that the client does not feel pain and appears to have superhuman strength. Clients are often fearful and suspicious and might react unpredictably to any stimuli. Providing a quiet, calming atmosphere will help decrease reactions. PCP causes no physical dependence; therefore, there will be no withdrawal symptoms. The client may have flashbacks long after the experience. Clients may fear they are crazy and will never be free of the aftereffects. Unlike PCP, clients withdrawing from LSD often respond to reassurance and may be talked down. Clients need to be frequently oriented and should be discouraged from closing their eyes because the symptoms may worsen.

**323.** A school nurse is counseling students after a fellow student died following inhalant use. The nurse includes the information that inhalants:

1. are costly and produce a prolonged effect without dependence or tolerance.
2. produce feelings of lethargy, vulnerability, and apathy.
3. have no withdrawal symptoms.
4. cause death due to cardiac arrhythmias or suicide.

(4) In addition to causing death, inhalants may result in permanent cognitive impairment. The withdrawal symptoms include headache, chills, and abdominal cramps. Inhalants are popular among preteens because of the low cost and easy availability.

**324.** A client states that she is codependent. The nurse explains that this means the client:

1. forms close personal relationships.
2. is preoccupied with the lives, feelings, and problems of others.
3. attempts to take responsibility for own behavior.
4. discourages the spouse to continue using drugs.

(2) Codependency implies a person is only satisfied in caring for others at the expense of personal health and welfare. Clients with codependency problems usually have low self-esteem and enable others to use drugs.

**325.** A client states, "If you had the problems I have, you would drink, too." The nurse documents the statement as using which coping mechanism?

1. denial
2. minimization
3. rationalization
4. problem-focused

(3) Clients who have substance disorders use many defense mechanisms, including denial, minimization, and rationalization. Rationalization involves offering an apparently logical explanation for the unacceptable behavior. Minimization is the underreporting of the behavior, possibly due to the client's lack of awareness of the rate of occurrence. Denial is one of the most commonly used coping mechanisms.

**326.** The desired outcome for a client withdrawing from a mood-altering substance would be for the client to:

1. have no withdrawal symptoms.
2. attend two support group meetings per day.
3. make a daily commitment to abstain.
4. recognize and talk about hallucinations or illusions.

(4) Although desirable, it is unrealistic to assume a client will have no withdrawal symptoms. The second and third choices are desired outcomes for the client who is abstaining from substance use after the withdrawal period.

**327.** A desired outcome for the client abstaining from using a mood-altering substance would be for the client to:

1. contact a support person when the urge to use the substance is experienced.
2. remain oriented to person, time, and place at all times.
3. correctly interpret environmental stimuli and discuss feelings about stimuli.
4. never be tempted to use the substance again.

(1) During abstinence, the client needs to recognize when the desire to use the substance is experienced and contact a support person. The other choices are outcomes for the withdrawal period.

**328.** A client is experiencing toxic psychosis from phencyclidine (PCP) use. An appropriate intervention would be:

1. continually have someone talk to the client in a calm reassuring voice.
2. instruct the client to close his eyes to decrease environmental stimuli.
3. to explain all procedures prior to performance.
4. provide therapeutic touch to reassure the client.

(3) PCP toxicosis causes agitation. Users are likely to strike out in response to misinterpretation and panic, potentially harming themselves or others. Because PCP is an anesthetic, the client will feel no pain and might appear to have superhuman strength. Clients should be placed where there is minimal stimulation until the effect wears off. The client will need frequent reorientation.

**329.** A client is in the emergency department after a motor vehicle crash that involved alcohol use. Which statement is true about harm reduction?

1. The client must admit he is an alcoholic before he can decrease his intake.
2. The client must abstain and agree to attend a 12-step program.
3. The nurse can help the client plan ways to prevent a reoccurrence.
4. This nurse needs to confront the client's denial of the problem.

(4) This is an excellent opportunity to help the client recognize the use of alcohol and the current situation. Often, due to denial, the client cannot connect the use of alcohol and the accident. The client can then decide upon a plan to prevent a future accident. Labeling the client as an alcoholic will result in the client becoming defensive. Some people are able to reduce their intake, while others need to abstain. The client will be more receptive to reduction than abstinence.

**330.** A client agrees to stop using marijuana. Select the best information for the nurse to teach the client about marijuana withdrawal.

1. Marijuana is not associated with withdrawal symptoms.
2. Seizures often occur during marijuana withdrawal.
3. The client might have flashbacks for months after abstaining from marijuana.
4. Dry mouth and nose are common symptoms during marijuana withdrawal.

(1) Marijuana usually has no withdrawal symptoms. Seizures may occur with alcohol and other depressant withdrawal. Flashbacks can occur for years after hallucinogen use. Dry mouth and red eyes are signs of marijuana use.

**331.** A client reports that he drinks because of his stressful job and wife's inability to care for the house and children. The nurse recognizes his comments as:

1. avoidance.
2. identification.
3. rationalization.
4. denial.

(3) Clients who abuse substances frequently use blame-placing and rationalization to explain their behavior. The nurse should limit rationalization and direct the client's focus to the substance abuse problem.

**332.** A parent asks the school nurse why they are teaching the third grade class about substance abuse. The nurse's best response would be:

1. "Gateway drugs lead the child to smoking and drinking."
2. "The average age to start smoking is 12 and drinking alcohol is 16."
3. "The children are at an age where they can put pressure on their parents to stop using drugs."
4. "Children at this age have already started experimenting with drugs."

(2) The age that children start smoking and drinking dropped in the late 1990s. In recent surveys, about half of all high school students had consumed alcohol in the past month. Prevention programs are targeted at students before they begin experimenting with drugs. Gateway drugs are drugs that lead to other drug use. Tobacco and marijuana are considered gateway drugs.

**333.** A client states, "I cannot be an alcoholic because I only drink beer." The nurse's best response would be:

1. "You are correct. Only hard liquor can cause alcohol addiction."
2. "How much beer do you drink at any one time? Women should not have more than two drinks on any given occasion."
3. "It is not the type of the alcohol that determines addiction, but the amount and the consequences."
4. "Since you binge drink, you are an alcoholic."

(3) The effects of alcohol determine the extent of the problem, not the type of alcohol consumed. The problem drinker or drug user may have undiagnosed medical or social problems but not yet have experienced a major loss of control. In full-blown addiction, clients continue using alcohol or drugs despite negative consequences, have a compulsion to continue using alcohol or drugs, and are in denial about the effects on themselves and others.

**334.** When providing information to parents of adolescents, the nurse would include which information about the consequences associated with teenage drinking?

1. The consequences depend on the individual's age, cultural background, family, and peers.
2. Alcohol use increases the risk of motor vehicle accidents, suicides, and violence.
3. Moderate to heavy drinking in adolescence is associated with a decreased risk of heart disease, hypertension, and arrhythmias.
4. A blood alcohol concentration (BAC) below the legal intoxication level will ensure risk-free driving.

(2) Alcohol use in adolescents increases the fatal and nonfatal vehicle accidents, suicides, homicides, violence, and delinquency. Consuming one alcoholic beverage a day by adults has a positive effect on heart disease and hypertension.

**335.** A client reports that he will not develop alcohol-related problems because he takes vitamins every day. The nurse's best response would be:

1. "That is excellent. A nutritious diet will protect drinkers from alcohol-related health problems."
2. "The major problems in people abusing alcohol are not compounded by poor nutrition."
3. "The choices you make about types of foods you eat will not affect how alcohol affects you."
4. "There are no assurances that taking vitamins will prevent liver disease or other health problems associated with drinking."

(4) Although drinkers benefit from eating healthy, there is no evidence that eating a healthy diet will prevent the physiological consequences of drinking. Many medical problems in people abusing alcohol are compounded by poor nutrition.

**336.** The nurse wishes to decrease the client's use of denial and increase the client's expression of feelings during a crisis intervention. In order to do this the nurse would:

1. tell the client to stop using the defense mechanism of denial.
2. positively reinforce each expression of feelings.
3. instruct the client to express feelings.
4. challenge the client each time denial is used.

(2) In crisis intervention, defenses are not attacked, but defenses are encouraged or discouraged. There is not enough time in crisis intervention to replace attacked defenses with new ones. Returning the client to a prior level of functioning is the goal, not restructuring of defenses.

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

1. "You feel inadequate because you have never learned to balance a checkbook."
2. "You should have insisted your husband teach you about the finances."
3. "You are strong and will learn how to manage your finances after a while."
4. "Why don't you take a class in basic finances from the local college?"

(3) Clients often feel helpless, overwhelmed, and inadequate during a crisis. Seeking help increases the feelings of inadequacy. The nurse raises the client's self-esteem by communicating confidence the client can participate in actively finding solutions to the problem. The nurse also conveys the client is a worthwhile person by listening and accepting the client's feelings and praising the client for seeking assistance.

**338.** Which of the following attitudes is essential in a nurse who assists clients during crises?

1. viewed crisis intervention as the first step in solving bigger problems
2. wants to help client solve all problems identified
3. takes an active role in guiding the process
4. feels work requires identification of all the client's problems

(3) Crisis intervention is a short term process that cannot identify or resolve all of the client's problems. The crisis worker should view this work as the treatment of choice. Assessment of the present problem should be viewed as necessary. Time and limitations of crisis work need to be remembered. Complete diagnostic assessment is unnecessary, and unrelated material should not be explored. Referrals may be necessary for other identified problems.

**339.** The nurse is working with families who have been displaced by a fire in an apartment complex. What is the priority intervention during the initial assessment?

1. Provide liaison to meet housing needs.
2. Attentively listen when clients describe their feelings.
3. Offer nurturing support for clients who are confused by the events.
4. Provide structure for clients exhibiting moderate to severe anxiety.

(1) After physical needs of housing, clothing, and food are met, the nurse would focus upon assisting clients to manage the psychological effects of the losses.

**340.** When planning intervention for a client during a crisis, the nurse would have a desired outcome to be:

1. client will explore deep psychological problems.
2. client will express positive feeling about event.
3. client will identify needs that are threatened by the event.
4. client will use constructive coping mechanisms.

(4) The primary goal of crisis intervention is to relieve the symptoms of anxiety and foster constructive coping. Previous psychological issues may recur during crisis, but the focus is on short-term resolution of the current problem. At the end, the nurse credits the client for positive changes and helps the client understand what was learned. This allows the client to use the learned coping mechanisms when new problems arise.

**341.** A man expresses surprise that his wife has become very withdrawn during hospitalization for pneumonia. Which response will help the husband understand how some people cope with hospitalization?

1. "Hospitalization may cause a crisis. Has your wife had to cope with problems before this?"
2. "Some people react that way. She will be more talkative when she feels better."
3. "Your wife may be feeling that she cannot fulfill her normal roles."
4. "This is typical behavior for someone who is as ill as your wife."

(3) Hospitalization may precipitate a crisis in either the client or family. Clients may become demanding or withdrawn. Family members may become demanding to help them cope with the insecurity.

**342.** Nurses seek assistance from a psychiatric clinical nurse specialist (CNS) to help manage the wife of a man who is recovering after a myocardial infarction. The wife is scrutinizing all interventions, complaining that the nurses are ignoring her husband, and criticizing the previous nurse's activities. The CNS's best response would be to:

1. validate the nurse's feelings of frustration.
2. talk with the client's wife about her feelings of helplessness.
3. refer the wife to group therapy to increase the wife's support.
4. help the nurse to explore how to decrease the wife's anxiety.

(4) Families of clients who have experienced a life-threatening illness may have difficulty coping with potential losses such as death of the client and financial security. The family members become hypervigilant and threaten the nurse's feelings of security. A helpful intervention is to assist the nurses to focus on decreasing the family's anxiety. The nurses can use methods learned in similar situations in the future.

**343.** A client comes to a mental health center after losing all of his belongings in a fire. Which is an appropriate short-term goal for the nursing diagnosis of "ineffective individual coping?"

1. The client will stop blaming himself for inappropriate electrical wiring.
2. The client will replace items destroyed in the fire to decrease the sense of loss.
3. The client will explore buried problems brought forward from this loss.
4. The client will share feelings about the present crisis .

(4) Expressing feelings brings about a positive release of emotions. Crisis intervention may identify deep psychological problems but does not attempt to resolve them. Replacing the destroyed items will not decrease the loss of the original items, and emotions attached to the items cannot be replaced.

**344.** A client is in the emergency department after being assaulted and robbed. The client is agitated and hypervigilant. The nurse's priority would be:

1. placing the client in a room away from activity.
2. examining and treating wound sites.
3. administering an antianxiety agent.
4. assisting the client to ventilate feelings.

(2) After treating physiological needs, the nurse can concentrate on managing the client's anxiety.

**345.** In the last week, five clients have died in the intensive care unit. Which intervention would be most helpful to reduce the nurse's stress?

1. providing literature on stress reduction
2. a "debriefing" session lead by a mental health nurse
3. individual counseling sessions with a mental health nurse
4. requiring each nurse to write out feelings in a journal each week

(2) A "debriefing" session will allow nurses to ventilate feelings and gain support from each other. Individual counseling sessions are not time- or cost-effective. Providing literature and journaling are not effective in reducing stress. Journaling is effective in identifying feelings.

**346.** A client has received counseling for a crisis situation following the death of a family member. Which statement indicates that no further teaching is required?

1. "I know that I will never feel out of control again."
2. "I have learned how to identify stress and how to deal with the feelings."
3. "I will take my Valium whenever I begin to feel stressed."
4. "I am embarrassed that I lost control. It will never happen again."

(2) The desired outcome of crisis intervention is that the client will return to at least the previous level of coping. Being able to identify stressors and manage the feelings shows that the client has effective coping. It is an unrealistic expectation to never feel stressed again or to rely on medication to manage stress.

**347.** An adolescent is brought to the mental health center after witnessing the death of a friend in a car crash. The nurse determines that this is which type of crisis?

1. maturational
2. situational
3. adventitious
4. situational and maturational

(4) Maturational crisis occurs during transitional periods that require a change in roles, such as adolescence, marriage, parenthood, and retirement. Situational crises occur during acute events such as job loss, loss of loved one, unwanted pregnancy, and medical illness. Adventitious crises occur during disasters with multiple losses. Combinations of crises events can occur. Frequently situational crises occur at transitional periods.

**348.** An elderly client is receiving counseling for "dysfunctional grieving related to loss of spouse of 48 years." Select a realistic outcome for this nursing diagnosis.

1. The client arranges to attend a community grief group with a friend.
2. The client discusses the connection between significant losses and low self-esteem.
3. The client verbalizes two alternatives to suicide.
4. The client lists three coping mechanisms to manage feelings of stress.



(1) Since the diagnosis is about grieving, the only option that matches is the first option. The other options are not focused on the dysfunctional grieving.

**349.** A client is being seen at a crisis center three months after a sexual assault. The client reports that “It feels like it happened yesterday.” The nurse’s best response would be:

1. “It happened three months ago. Don’t be irrational.”
2. “What causes you to feel like it just happened?”
3. “What are you doing to prevent being assaulted again?”
4. “What type of stress reduction activities are you practicing?”

(2) The nurse should portray a nonjudgmental attitude and reassure the client that her feelings are normal. The nurse addresses the client’s feelings. The other options belittle the client or address activities, not feelings.

**350.** A nurse is planning care of a client admitted for attempted suicide. Which intervention will the nurse include in the plan of care?

1. Check the client every 15 minutes.
2. One-to-one suicide precautions.
3. Teach the client to report any suicidal thoughts.
4. Place the client on bedrest with bilateral wrist restraints.

(2) A serious threat of suicide requires constant one-to-one observation. Based on Maslow’s hierarchy, safety is the priority when physiological needs are met.

**351.** What is the correct term for the situation characterized by a person or group of persons experiencing a stressful event(s) that results in failure of usual coping mechanisms and/or the utilization of problem-solving resources?

1. crisis
2. stressor
3. depression
4. hypomania

(1) A crisis is characterized by severe disorganization precipitated by failure of customary coping mechanisms or lack of or failure of usual resources. A stressor may be an event or event(s) extrinsic or intrinsic that combines with other factors to bring about the crisis situation. Depression and/or hypomania may result from sustained crisis situations and ineffective resolutions.

**352.** A young child experiences the death of an older sibling. Which of the following behaviors indicates the need for mental health referral?

1. sleep disturbances beyond six months
2. initial weight loss and eating disturbance
3. crying
4. preoccupation with memories, sayings of the deceased, and redecoration of the bedroom with photos, drawings, and other reminders of the deceased

(1) All of the behaviors can be expected during acute loss and bereavement; however, when symptoms such as sleep disturbances become protracted, medical intervention and/or counseling are necessary.

**353.** The nurse should recognize that a pregnant woman is experiencing a crisis when she says:

1. “Being pregnant is such a challenge.”
2. “This whole pregnancy thing is all so new to me.”
3. “I was always so strong, and now I can’t seem to cope.”
4. “Sometimes I want to be a mother, and other times I don’t.”

(3) A crisis occurs when the usual coping mechanism fail to prevent an increase in anxiety. Pregnancy may cause a maturational crisis, especially an unwanted pregnancy.

**354.** A crucial factor the nurse needs to identify during crisis intervention for a pregnant woman is the woman's:

1. available support systems.
2. history of unresolved problems.
3. underlying psychological conflicts.
4. ability to restructure her personal relationships.

(1) Crisis intervention is short-term and focuses upon the current problem. The crisis worker will select which areas can be helped by crisis intervention. Other problems that are identified may require referral. Interventions for crisis situations include increasing the support system and development of new coping mechanisms.

**355.** A man becomes restless and anxious following retirement. He states, "I do not know what is wrong with me. I was looking forward to having the time to do my favorite hobbies. Now I cannot concentrate on anything." The nurse suspects the client is developing which type of crisis?

1. maturational
2. adventitious
3. situational
4. transitional

(1) There are three types of crises. Maturational crisis occurs during transitional periods that require a change in roles, such as adolescence, marriage, parenthood, and retirement. Situational crises occur during acute events such as job loss, loss of loved one, unwanted pregnancy, and medical illness. Adventitious crises occur during disasters with multiple losses.

**356.** A nurse is working with an Asian American client who has developed anxiety while seeking a new job. The client had the previous job for 10 years and feels uncertain of skills. When working with a client from a different culture the nurse would:

1. assess own cultural beliefs and influence client to accept those beliefs.
2. recognize own beliefs may interfere with helping client from another culture.
3. read about the other culture and expect client to exhibit those traits.
4. expect client to conform to the dominant culture's behaviors and attitudes.

(2) Cultural attitudes strongly affect the nurse's communication style and attitudes toward managing problems. In addition, the client's culture determines the processes for asking for, giving, and receiving help. Cultural factors to be considered include citizenship, gender, family role, religious beliefs, child raising practices, extended family relationships, and the support system.

**357.** A nurse is talking to a client who was diagnosed with diabetes mellitus two days ago. The client states, "No one in my family has diabetes. My sister has been overweight all her life; she should be the one with diabetes. I cannot manage the diet and testing. I want the tests rerun." The nurse identifies the client is in which stage of crisis?

1. impact
2. honeymoon
3. disillusionment
4. reconstruction

(1) Five stages of crisis resolution have been identified. Initially the client feels the impact of the situation and experiences shock, denial, panic, and fear. Constructive activity occurs during the heroism phase. The honeymoon stage occurs when the client exhibits a desire to help others. Disillusionment occurs next with the client comparing his plight with that of others. During reconstruction, the client will rebuild his life.

**358.** While discussing sexual orientation and mental health with a client, the nurse includes which information?

1. Lesbians have higher self-esteem than heterosexual women.
2. Gay and lesbian youth have the same rate of attempted suicide as heterosexual youth.
3. Major depression and substance use are higher in lesbian and gay youth.
4. Men and women reporting same-sex partners use less mental health services.

(3) Gay men, lesbians, and bisexuals appear to have higher rates of mental depression, anxiety, and substance use than heterosexuals; discrimination may help to fuel these rates. Gay and lesbian youth are more likely to attempt suicide. Higher use of mental health services are found in men and women reporting same-sex partners.

**359.** Antidepressants are considered the treatment of choice for major depression; however, they should be used with caution in clients with:

1. respiratory disease.
2. cardiac disease.
3. renal disease.
4. liver disease.

(2) Tricyclic antidepressants may cause orthostatic hypotension, tachycardia, and conduction defects. Amitriptyline has been shown to cause sudden cardiac death in clients with pre-existing heart disease. Tricyclic antidepressants improve ventricular dysrhythmias. Second generation antidepressants (Maprotiline, Trazodone, Fluoxetine) cause decreased heart rate and orthostatic hypotension. Clients receiving antidepressants require serial blood pressure and electrocardiogram monitoring.

**360.** A client diagnosed with bipolar disease has begun a regimen of lithium. The most critical issue for the first two weeks is:

1. monitoring the blood pressure.
2. educating about side effects of the medicine.
3. ensuring blood levels reach a therapeutic level.
4. ascertaining that the client receives the full dose.

(3) Lithium may take 2 weeks to reach therapeutic levels. The client will be tested periodically to ensure that the blood level of the drug is at a therapeutic level.

**361.** A client has been receiving lithium for a diagnosis of bipolar disorder. The client reports new onset of hand trembling, dizziness, and stumbling. The nurse would:

1. reassure the client these are temporary side effects.
2. monitor these effects to make sure they do not worsen.
3. notify the prescriber that the client is showing signs of toxicity.
4. request the client return in three days when the prescriber is present.

(3) Lithium has a very narrow window of effectiveness. Side effects that may be temporary include nausea, vomiting, diarrhea, hand tremors, muscle weakness, thirst, fatigue, and drowsiness. Signs of lithium toxicity include nausea, drowsiness, confusion, slurred speech, blurred vision, muscle twitching, and cardiac dysrhythmias.

**362.** When working with a client who has been started on a psychotropic medication, the nurse would assist the client to adhere to the medical regime by:

1. informing the client that side effects are temporary.
2. using community and family support available to the client.
3. requesting the client make an appointment in four weeks.
4. maintaining a casual, social relationship with the client.

(2) Involving the family and increasing support through community resources will help the client adhere to the regimen. The client needs to be monitored closely for adherence and side effects of the medication.

**363.** An elderly client is being placed on a psychotropic medication. The nurse recognizes that older adults:

1. require a higher dose because the medicine is not absorbed.
2. often do not have an effective response to psychotropic medicines.
3. are reluctant to take medicine because of the stigma attached to mental illness.
4. usually require a lower dose of medicine due to decreased metabolism.

(4) Hepatic and renal function declines with age. Therefore, medications are often metabolized more slowly in older adults, resulting in a longer half-life. The dose needs to either be decreased or the time between medication dose increased.

**364.** During the 6-month well child visit, the nurse notices the mother is unkempt and tearful. The mother reports extreme fatigue and feelings of inadequacy. The nurse would document the mother may be experiencing postpartum:

1. blues.
2. depression.
3. psychosis.
4. melancholia.

(2) Postpartum blues occurs within five days of delivery, lasts 1–2 weeks, and is due to hormonal changes and fatigue. Postpartum depression can occur from 2 weeks to 1 year after delivery, but often is seen about 6 months. Postpartum psychosis usually occurs within the first week after delivery and is associated with hallucinations, paranoia, confusion, rapid speech, and mood swings.

**365.** What is the best nursing intervention when a client is experiencing a panic attack?

1. “Please try to concentrate on what I am saying.”
2. “Let’s go for a short walk until you are calmer.”
3. “Just sit back in your chair and take a few deep breaths.”
4. “I am going to get you some Valium now.”

(4) Panic results in disorganized thinking and loss of the ability to concentrate. The client is unable to use relaxation techniques or other anxiety-reducing activities.

**366.** A client is transferred to an inpatient psychiatric unit after treatment for self-inflicted burns. What is the nurse’s highest priority?

1. client protection
2. suicidal assessment
3. impulse control
4. self esteem

(1) With self-inflicted injuries, the highest priority is to ensure the client does not harm self or others. The other interventions are desirable after the client’s safety is ensured.

**367.** Which of the following assessment findings is likely for a client with anorexia nervosa?

1. hyperkalemia
2. dysmenorrhea
3. dehydration
4. dental erosion

(4) Dental erosion occurs due to the gastric acid with frequent vomiting. Hypokalemia also results from loss of electrolytes in gastric fluid. A female with a body weight of less than 90 pounds may have amenorrhea.

**368.** A client with anorexia nervosa weighs 80 percent of normal body weight and states “I am so fat I cannot get into my clothes.” The nurse’s best response would be:

1. “You are under your ideal body weight, and it is causing you medical problems.”
2. “You only weigh 100 pounds. How can you say you are fat?”
3. “You need to stop thinking like that. How else can you describe your body?”
4. “Why do you perceive yourself to be fat?”

(1) The best response is to provide a factual nonjudgmental answer. The client is not able to explain why they have a distorted perception.

**369.** A client diagnosed with bipolar disease is running in the halls and entering other client’s rooms. Select the nurse’s best response.

1. “You need to walk with me to get some medicine to help you calm down.”
2. “You need to stay out of other peoples rooms.”
3. “If you cannot stay in the living area, you will need to stay in your room.”
4. “Why are you running in the halls?”

(3) The nurse needs to consistently set and enforce limits on undesirable behavior for the client experiencing the manic phase of bipolar disease. This answer provides the client with information about the acceptable behaviors.

**370.** A client is admitted following a suicide attempt. The client is disheveled, disorganized, and dehydrated. The priority for the first 24 hours is:

1. hydration by forcing fluids.
2. assisting with showering and clean clothes.
3. assessing factors that contributed to suicide attempt.
4. protecting client from self.

(4) Clients at risk for self-inflicted harm need to be protected. Assisting the client with hydration and showering are less important, as is determining the reasons for the attempt.

**371.** The nurse determines that a client has symptoms of tardive dyskinesia and:

1. records the physical symptoms and client statements.
2. withholds the next dose of the medication.
3. documents the medication has the desired effect.
4. consults the psychiatrist for an anticholinergic drug.

(4) Tardive dyskinesia is a neurologic disorder caused by long-term use of neuroleptic drugs. Although there is no cure, many of the symptoms can be managed with anticholinergics, dopamine agonists, and benzodiazepines.

**372.** A family member of a client with a diagnosis of schizophrenia asks about the prognosis. The nurse’s response is based upon the knowledge that schizophrenia:

1. affects women more often than men.
2. usually is diagnosed between the ages of 15 and 45.
3. is a chronic deteriorating disease with periods of remission.
4. is diagnosed later in women due to a protective hormone effect.

(3) Although all of the answers are true about schizophrenia, only option 3 answers the question asked.

**373.** A client receiving pre-operative instructions asks questions repetitively about when to stop eating the night before the procedure. The nurse repeatedly tries to refocus the client on other aspects. The nurse notes the client is frequently startled by noises in the hall. Assessment reveals rapid speech, trembling hands, tachypnea, tachycardia, and elevated blood pressure. The client admits to feeling nervous and having trouble sleeping. Based upon the assessment, the nurse documents the client has:

1. mild anxiety.
2. moderate anxiety.
3. severe anxiety.
4. a panic attack.

(3) With mild anxiety, stimuli are readily perceived and processed; the ability to learn and problem solve is enhanced. Moderate anxiety narrows the perceptual field, but the client will notice things brought to his attention. In severe anxiety, the client focuses upon small or scattered details. The person is unable to problem solve. During a panic attack, the person is disorganized and may be unable to speak or act or may be hyperactive.

**374.** A client reports that someone is in the room and trying to kill him. The nurse's best response would be:

1. "There is no one in your room. Let's get you more medicine."
2. "I do not see anyone, but you seem to be very frightened."
3. "No one can hurt you here."
4. "Just tell the person to go away."

(2) It is important to acknowledge the client's fear. The other actions deny the client's perceptions.

**375.** The nurse is developing a care plan for the client with severe anxiety. Within 4 days the client will:

1. have decreased anxiety.
2. talk to the nurse for 10 minutes.
3. sit quietly for 30 minutes.
4. develop an adaptive coping mechanism.

(2) Outcome criteria need to be specific, measurable, and realistic. Talking for 10 minutes meets all of these conditions. It is not realistic to expect a severely anxious client to sit quietly for 30 minutes. The other statements are vague and not measurable.

**376.** An effective intervention for a client diagnosed with an obsessive compulsive disorder would be:

1. discuss the repetitive action.
2. insist the client not perform the repetitive act.
3. inform the client the act is not necessary.
4. encourage daily exercise.

(4) Obsessive compulsive disorder is an anxiety disorder. Exercise will release emotional energy, limit time for the maladaptive behavior and direct the client's attention outward. Initially, nurses should not interfere with performance of the repetitive act, try reasoning the client out of the behavior or ridicule the behavior.

**377.** A man reports his wife is constantly cleaning. The activity has interfered with the family life. Friends have stopped visiting because she makes them uncomfortable. He states he has awakened in the middle of the night and found her cleaning. The nurse consults with the couple and recommends the husband can help with therapy by:

1. telling his wife to stop cleaning whenever he notices her actions.
2. making a baseline record of the time the wife spends cleaning.
3. decreasing the stimuli in the home.
4. helping his wife with cleaning.

(3) His wife is exhibiting obsessive compulsive behavior. Since this is an anxiety disorder, it is desirable to maintain an environment that is calm and as stress free as possible. Attempting to stop or focusing on the behavior can increase the wife's anxiety and, therefore, the repetitive behavior.

**378.** When helping the client gain insight into anxiety, the nurse would:

1. help relate anxiety to specific behaviors.
2. ask the client to describe events that precede increased anxiety.
3. instruct the client to practice relaxation techniques.
4. confront the client's resistive behavior.

(2) To gain insight, the client needs to recognize causal events. The other activities focus on recognition of when anxiety is occurring and how to manage the anxiety.

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

1. "I can drink alcohol now that I will be decreasing my Xanax."
2. "I will not take another Xanax pill. Here is what is left of my last prescription."
3. "I will take three pills per day next week, then two pills for one week, then one pill for one week."
4. "I can expect be sleepy for several days after stopping the medicine."

(3) Xanax, like other benzodiazepines, causes withdrawal symptoms including agitation, insomnia, hypertension, seizures, and abdominal pain. The drug needs to be slowly decreased to prevent these side effects. The drug must be tapered slowly to minimize rebound symptoms of insomnia and anxiety. If symptoms occur, the dose needs to be raised again until symptoms are gone and tapering resumed at a slower rate.

**380.** A nurse is assisting a client who reported being abused by her partner. The client has chosen not to leave the situation. The first intervention by the nurse would be to:

1. help the client assess how leaving or staying affects her risk.
2. provide a list of shelters and their phone numbers.
3. ensure the client's safety by obtaining a restraining order.
4. notify law enforcement of the danger to the client.

(1) Advocacy involves engaging in a risk analysis with the client based on her perceptions. An advocate needs to find out what a client perceives as risks and how the advocate can most effectively use this information to advance the woman's plans and priorities. If the nurse does not determine the client's concerns, they may work at cross purposes. If the client wishes, the nurse can provide a list of resources. The client will determine the risk involved if the batterer finds the list. A restraining order may be obtained, but it is not the first priority and will not ensure the client's safety. The same is true of notifying law enforcement.

**381.** A client who has reported being the victim of domestic violence decides not to seek shelter at this time. The nurse advises the client to have a bag packed and to rapidly leave the situation if feeling endangered. Which items are considered essential for the client to take when escaping?

1. herself and the children
2. marriage license and birth certificates
3. blank checks
4. records of income

(1) If violence is eminent, the client should leave with the children. The abuser's permission is not required for the children to leave. It would be useful to have the documents listed, but the safety of the client and children are paramount. The client can take the car and other household goods if the situation allows. Property of the family is usually regarded as belonging equally to both partners. The client should immediately contact a domestic violence assistance program.

**382.** A client reports being hit in the stomach by her boyfriend, John Smith. The nurse would document this as:

1. "Client reports being hit by boyfriend."
2. "Client reports being hit in abdomen by boyfriend, John Smith. No bruising observed."
3. "Client tearful, clutching abdomen. Says it is boyfriend's fault."
4. "Client hysterical. Says boyfriend hit her two hours ago. There is no bruising, and it should be present."

(2) The nurse would objectively document client statements, emotional status, and physical signs. If the client names the perpetrator, the nurse should document it. A diagram of any visible signs of injury or pictures will be very helpful if the nurse is requested to testify, often months after the incident. If the client is an adult, the client must consent to the pictures.

**383.** A client's injuries are not consistent with how the client reported the accident. The client denies the injuries are the result of abuse. The nurse would document:

1. only the client's explanation.
2. only the physical findings with a diagram of the injuries.
3. only the client's explanation and the physical findings with a diagram of the injuries.
4. an opinion that the injuries are not consistent with the client's explanation.

(4) The practitioner can document the opinion that the explanation is not consistent with the findings. In addition the nurse would record the client's explanation and detailed physical assessment findings. A diagram and/or pictures of the injury are also helpful.

**384.** While talking with a client who has been abused by the partner, the nurse recognizes which factor as strongly indicating the partner is capable of killing the client?

1. The partner has many friends.
2. The partner abuses the client's pet.
3. The partner is considering filing for separation.
4. The partner suggests the client have more friends.

(2) Although all batterers are dangerous, some are more likely to kill than others are, and some are more likely to kill at specific times. Assessment is difficult and never foolproof. Factors that indicate the batterer may be likely to kill include threats of homicide or suicide, expressing ownership of the client, threatening client with weapons, disregard for law enforcement, and harming pets. Another indicator is escalating violence toward the client. Batterers are more dangerous if they are isolated or isolate the victim.

**385.** Which statement is true concerning victims of domestic violence?

1. Leaving the situation ensures the victim's safety.
2. The victim's goal is to remain alive or get out of the situation safely.
3. The victim is willing to testify regardless of the batterers claims of retaliation.
4. The victim will follow through with the criminal justice system, even if in danger.

(2) The victim will do whatever it takes to feel safe. A victim is at great risk after she takes steps or indicates her intent to leave. The abuser will likely increase the tactics used to control her. Each person has a separate role in the system. The victim's role is to stay safe.

**386.** There are three phases in the Cycle of Violence described in *The Battered Woman* by Dr. Lenore Walker. In which phase is the batterer contrite and loving?

1. honeymoon
2. tension building
3. battering
4. plateau



(1) Phase one is tension building, in which the abuser becomes more and more prone to react to any stimulus negatively. Phase two is the battering incident. The victim may not do not experience the full emotional impact of the attack until 24 to 48 hours after it has occurred. Phase three is characterized by remorse and promises to never be violent again. The batterer truly believes that he will never again hurt the woman he loves, and that he will be able to control himself from now on. He also believes that he has taught his partner such a lesson that she will never again behave in a way that tempts him to physically assault her. He is quite sincere and can easily convince anyone involved that his behavior will change.

**387.** A nurse is discussing the cycle of domestic violence with a client. The client reports that her partner has just bought her an expensive gift and is taking her on a wonderful vacation. The client reports the partner vows to never hit again. The nurse would document the client is in which stage in the cycle of violence?

1. plateau
2. escalation
3. honeymoon
4. celebratory

(3) Three stages are described in the cycle of violence: tension building, battery, and honeymoon. In the tension-building phase the victim responds to the escalation in tension by trying to nurture or appease the perpetrator. The batterer becomes more oppressive, jealous, threatening, and possessive. Immediately after the battery, both the batterer and the victim find ways of rationalizing the seriousness of the attack. In phase three, the batterer begins an intense campaign to win forgiveness and to prevent his victim from separating permanently. It is common for an abuser in phase three to shower the victim with elaborate gifts and to attempt to “romance” the victim into forgiveness.

**388.** As an advocate for the client who has suffered domestic abuse, the nurse would:

1. instruct the client to leave the partner.
2. connect the client with legal and financial resources.
3. advise the client about legal rights throughout prosecution.
4. empower the client to make significant change.

(4) Nurses can provide a lifeline to women and children who desperately need assistance and direction but are confused by the dynamics of their victimization, the thought of leaving a violent environment, and, in some cases, entering into the criminal justice system. The nurse’s role is to assess the situation and help the client problem solve and make changes.

**389.** When a woman reports domestic violence the nurse would:

1. seek verification from a second source.
2. not mention the subject again because it is too sensitive.
3. enforce that the client is not responsible or to blame.
4. ask why the client did not report this when it started.

(3) When working with victims of domestic violence the nurse must be validate the victim’s feelings, experiences, and fears. Many domestic violence victims do not view themselves as victims and fail to realize that domestic violence is prevalent. When assessing the situation, the nurse asks for a complete history including the current incident as well as the first and worse incidents. The nurse asks the client to describe the violent acts in detail and how the client felt when the incidents occurred and how she feels now.

**390.** When assessing the client who has been charged with being a batterer, the nurse expects to find:

1. a very social outgoing person with good stress management skills.
2. the client reporting the partner is the sole source of love and support.
3. a person with good insight into reasons for behavior.
4. a person who admits responsibility for the behavior.

(2) Batterers are usually male and exhibit low self-esteem. They are frequently angry, depressed, and depend on the partner as their sole source of love, support, intimacy, and problem solving. The batterer and victim deny or minimize the scope and severity of the violence. Batterers frequently claim the victim was at fault because the victim failed to meet the batterer's expectations.

**391.** Which of the following assessments indicates a client is at high risk for violence while in the hospital?

1. The client has never used drugs or alcohol.
2. The client is withdrawn and depressed.
3. The client states that "everyone is out to get me."
4. The client is cooperative and cheerful.

(3) High risk factors for violence include substance abuse, history of violence, verbal expressions of anger or frustration, and threatening gestures. Clients who are depressed usually do not have the energy to be violent.

**392.** The nurse would include which intervention in the plan of care for a client who has been abused by the spouse?

1. Ask for the client's perception of the need for protection.
2. Report the abuse to authorities.
3. Counsel the client and abuser together.
4. Pressure the client to leave the situation.

(1) Victims of abuse have a very realistic view of how much danger they are in. In most states, nurses are not mandated to report adult victim of abuse, just child, elder, or dependent abuse. The client may not feel safe if the abuser is present; therefore, the nurse needs to meet with the victim separately.

**393.** The number of men abused by women is not known because:

1. very few men are abused.
2. the legal system believes the male is the aggressor, not the woman.
3. healthcare providers do not believe the man's story.
4. men tolerate more pain than women.

(2) Less men report abuse by women because of embarrassment. Healthcare and law enforcement professionals are more likely to accept alternative explanations of abuse from a man. They will believe other reasons for the presence of bruises and other signs of injury. Our justice system sometimes takes the word of the woman above the word of the man in abuse cases. It is just more believable that the aggressor was the man, not the woman.

**394.** Which of the following is the strongest indicator of domestic violence?

1. Caucasian race
2. African American race
3. witness of domestic violence in childhood
4. lower socioeconomic class

(3) The strongest indicator for domestic violence is past family violence. Male children who witness their mother's beating typically grow up to be perpetrators and females grow up to be victims. Racial and socioeconomic factors are not as reliable as indicators as domestic violence crosses all lines of both.

**395.** The nurse is working with a female who has been battered by her spouse, and she tells the nurse that she has to go back because he will kill her if she doesn't. What is the nurse's next course of action?

1. Call the police with the new information.
2. Notify the supervising nurse.
3. Arrange safe lodging at a women's shelter.
4. Discuss the matter with a social worker.

(3) The nurse must ensure the woman's immediate safety. The other disciplines are needed in the most effective treatment plan, but paramount is the immediate physical safety of the patient.

**396.** After group therapy, the female victim of intimate partner violence confides in the nurse that she does not feel in any immediate danger. Which of the following facts suggests to the nurse that this statement is correct?

1. Victims of domestic violence are often the best predictors of their risk of harm.
2. Victims of domestic violence often overestimate their safety risk.
3. Victims of domestic violence are typically in a state of denial.
4. Victims of domestic violence know that keeping peace with their partner is the best method of preventing another attack.

(1) Victims of domestic violence are often correct at predicting their risk of harm. However, the nurse would ensure that the patient is expressing herself authentically and is not trying to convince the nurse that there is no immediate danger. Further, proper authorities should be alerted to this reportable offense such as the police.

**397.** A 32-year-old female frequently comes to her primary care provider with vague complaints of headache, abdominal pain, and trouble sleeping. In the past, the doctor has dutifully prescribed medication, but little else. Which of the following statements by the nurse to the doctor are correct?

1. "Often women who are victims of domestic violence suffer vague symptoms such as abdominal pain."
2. "Often women will become offended if asked about their safety in relationships."
3. "It is mandatory that all women are questioned about domestic violence."
4. "How would you feel to know that her partner is beating her and you didn't ask?"

(1) There is a correlation in vague symptoms such as abdominal pain and battered syndrome. The astute clinician should ask any woman who presents with suspicious symptoms such as these. Rarely are women offended by a properly worded question, such as, "Do you feel safe in your present relationship?", and studies show the increase in case-finding that results by even one such question. It is not mandatory that all women are assessed for violence, but it is prudent that all persons new to a clinician be assessed by at least the one question noted above. Castigating or shaming the doctor will typically not improve patient outcomes and may make for a difficult working environment for the nurse. Such tactless comments are not collegial and should be avoided.

**398.** Which of the following describes the stages of domestic violence in an intimate relationship?

1. happiness, crisis, angry outburst, intervention
2. honeymoon period, escalation of stress, outburst, reconciliation
3. acting out and making up
4. peace and calm, angry outburst, peace and calm, denial

(2) A pattern of behavior known as the cycle of abuse has been described in the literature. It involves a honeymoon stage followed by build-up of stress, an angry outburst that may involve beating, followed by reconciliation and the honeymooning phase. Patients who do not receive help are at increased risk including homicide.

**399.** The kind of man who beats a woman is a man:

1. from a minority culture in the lower income group.
2. from a majority culture in the middle-income group.
3. who was never allowed to compete as a child.
4. from any walk of life, race, income group, or profession.

(4) Batterers cannot be predicted by any demographic feature related to age, ethnicity, race, religious denomination, education socioeconomic status, or class. Ninety-five percent of domestic abuse cases are male perpetrators and female victims. Same-sex partners may also be abused as well as females abusing male partners.

**400.** A batterer is usually someone who:

1. grew up in a loving, secure home.
2. was an only child.
3. was physically or psychologically abused.
4. admits they have a problem with anger.

(3) Many batterers report having been abused as children. Children who witness domestic violence are more likely to become a perpetrator or victim as adults than children who were victims of domestic violence.

# Basic Care and Comfort

This chapter contains questions and answers from the following topic areas:

- Alternative and Complementary Therapies
- Assistive Devices
- Elimination
- Mobility/Immobility
- Non-Pharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Palliative/Comfort Care
- Personal Hygiene
- Rest and Sleep

**1.** Which procedure is done at least twice whenever a splint is applied?

1. elevation of the injured extremity
2. manual stabilization of the injured extremity
3. assessment for pulses, sensation, and movement distal to the injury
4. application of gentle manual traction

**(3)** The procedure, which is done at least twice whenever a splint is applied is assessment for pulses, motor function, and sensation (PMS) distal to the injury. After traction is applied, it is not reapplied.

**2.** The objective of realignment is to:

1. minimize blood loss and reduce pain.
2. immobilize the bone ends and adjacent joints.
3. assist in restoring circulation and to fit the extremity into a splint.
4. prevent incorrect healing and avoid surgery.

**(3)** The objective of realignment is to assist in restoring circulation and to fit the extremity into a splint.

**3.** To ensure proper immobilization and increase patient comfort when using a rigid splint:

1. place the patient on a stretcher before splinting.
2. place the patient on a long spine board before splinting.
3. pad the spaces between the body part and the splint.
4. ensure that the splint conforms to the body curves.

**(3)** To ensure proper immobilization and increase patient comfort when using a rigid splint, pad the spaces between the body part and the splint.

**4.** The method of splinting is always dictated by:

1. location of the injury and whether it is open or closed.
2. the severity of the patient's condition and the priority decision.
3. the number of available rescuers and the type of splints.
4. all of the above.

**(2)** The method of splinting is always dictated by the severity of the patient's condition and the priority decision.

**5. Hazards of improper splinting include:**

1. aggravation of a bone or joint injury.
2. reduced distal circulation.
3. delay in transport of patient with life-threatening injury.
4. all of the above.

(4) Hazards of improper splinting include aggravation of a bone or joint injury, reduced distal circulation, and delay in transport of patient with life-threatening injury.

**6. The nurse should have the client use appropriate safety measures with care by:**

1. placing the cane on the affected side.
2. placing the cane on the opposite affected side.
3. does not matter which side the cane is on.
4. choice of cane placement should be the choice of the client.

(2) Safety demands that the cane be opposite the affected limb to provide support to the weakened extremity, thus preventing falls.

**7. A cane assists the client to walk with greater balance and support. Canes have the following features for safety and support:**

1. feet (four, three, straight), adjustable to allow the elbow to bend slightly, a rubber cap.
2. feet (straight or two), adjustable to what the client feels is best.
3. four feet, a rubber tip at both ends.
4. three feet, enables speed, using two canes.

(1) The cane can have four feet (quad), three feet (tripod), or be straight; the length should allow the elbow to bend slightly, and a rubber tip prevents slipping.

**8. The standard walker is used when clients:**

1. have poor balance, cannot stand up, have weak arms, and have good hand strength.
2. have poor balance, broken leg, or amputation.
3. have poor balance, cardiac problems, and cannot use crutches or cane.
4. have poor balance, autoimmune diseases, and weak arms.

(3) The use of the walker is used for clients who have balance, cardiac problems, or who cannot use crutches or cane. The client needs to be partial weight bearing and have strength in wrists and arms. The client uses upper body to propel the walker forward.

**9. Safety measures for crutches must be in place for a client when the nurse is the primary one for assistance. These safety measures are:**

1. to be propel fitted for the client, have rubber tips at the end, and provide for a four-point gait.
2. properly fitting crutches, education in the appropriate gait, and strength in the arms.
3. crutches fitting to what the patient chooses, and gait chosen by patient.
4. have both legs that touch the floor for all gaits.

(2) In addition to the rubber tips on the end of the crutch, the patient needs to know the appropriate gait; arm strengthening exercises are necessary, and it is critical that the patient be fitted for the crutch.

**10.** The Hydraulic Lift (Hoyer Lift) is used for:

1. all clients with orthopedic surgery.
2. all clients who are not able to stand and extremity obese clients.
3. all clients, both old and young in the hospital setting.
4. not an assistive device for special needs.

(2) The Hydraulic Lift is used for safety purposes when a patient is not able to stand or is too heavy for the healthcare workers to lift safely.

**11.** A client in balanced suspension traction for a fractured femur needs to be repositioned toward the head of the bed. During repositioning the nurse should:

1. place slight additional tension on the traction cords.
2. release the weights and replace immediately after positioning.
3. lift the traction and the client during positioning.
4. maintain the same degree of traction tension.

(4) Traction is used to reduce the fracture and must be maintained at all times, including during repositioning. It is not appropriate to increase traction tension or release or lift the traction during repositioning.

**12.** Which of the following is an abnormal finding in the physical assessment of the musculoskeletal system?

1. upper extremities having symmetric, equal muscles
2. gait balanced, stride smooth and regular
3. flexion, extension, and rotation of the neck
4. opposition of three of the four fingers to the thumb

(4) Opposition of three of the four fingers to the thumb is an abnormal finding in the physical assessment of the musculoskeletal system. A client should be able to do this without difficulty and easy flexibility.

**13.** Which of the following mobilization devices is usually preferred for the older adult?

1. crutches
2. cane
3. walker
4. wheelchair

(3) Walker-mechanical device with four legs for support this type of device is more supportive and has less expendable energy by the older adult than crutches or a cane. More independence is required than the wheelchair.

**14.** Nursing diagnosis for the child with a disorder of the musculoskeletal system includes:

1. high risk for activity intolerance, pain, high risk for injury.
2. pain, high risk for weight gain, high risk for abuse.
3. high risk for altered tissue perfusion, high risk for deformity.
4. pain, low risk for skin integrity problems; low risk for injury.

(1) Nursing diagnosis for a child with a disorder of the musculoskeletal system may include: high risk for activity intolerance, pain, diversional activity deficit, high risk for injury, impaired physical mobility, self-care deficit, body image disturbance, high risk for impaired skin integrity, and altered tissue perfusion peripheral.

**15.** Which is the traction that is used primarily for children due to the factor infants and toddlers do not have enough body weight?

1. Milwaukee traction
2. open traction
3. Bryant's traction
4. Jones' traction

(3) Bryant's traction is used where the body is its own counterweight; both legs are at 90-degree angles to the bed; buttocks must be slightly off mattress; used with children under 2 years whose weight is under 30 lbs. (14kg); used for fractured femur and dislocated hip.

**16.** The orthopedic device made of metal or leather applied to the child's body, particularly the trunk and lower extremities to support the weight of the body, to correct or prevent deformities, and to prevent involuntary movements in a spastic condition is the:

1. Milwaukee brace worn 23 hours/day, removed once daily for bathing.
2. Jones' brace worn continuously for 6 weeks.
3. Bryant brace extends from chin to feet.
4. Lee's brace used to stabilize extremity.

(1) The Milwaukee brace is of steel and leather fitted and adapted to the child; used in scoliosis to correct curvature; worn 23 hours/ day, removed once daily for bathing; causes little interference with activity.

**17.** Nursing care of the child with a brace includes:

1. no more care than usual child care and comfort.
2. increase observation of the child as for falling, particularly out of bed.
3. increase calories to 2000+/24 hours.
4. meticulous skin care and observation and adequate protein and fluid intake.

(4) Nursing care of the child should include: meticulous observation of skin for breakdown; meticulous care for cleanliness; maintaining dry padding under brace; observing for child's growth and adjustment of brace; maintaining adequate protein and fluid intake; making sure child experiences minimal discomfort; preventing injury; educating of parents or caretakers about child, care, and comfort.

**18.** Nursing intervention in a child with a clubfoot (Talipes) includes:

1. assessment of child with cast/brace, diversional activities; passive exercises to correct position of foot.
2. assessment of child with cast/brace, let child stand up and walk around bed.
3. provide for skin care, diversional activities, educational information for cast/brace immobilization device.
4. provide for comfort, nutrition, and ROM exercises.

(3) Nursing interventions for a child with a clubfoot (Talipes) should include: constant assessment of child for discomfort, growth, and development; activities for the child and nutritional needs; skin care; no standing or walking during treatment; no ROM exercises to correct foot position; cast care; teaching.

**19.** Doug, age 3, has a fractured femur and is in Bryant's traction. To evaluate the correct application of the traction, the nurse should note that:

1. Doug is being continuously and gradually pulled toward bottom of bed.
2. Doug's buttocks are raised slightly.
3. Doug's leg is in a 45-degree angle to the bed.
4. Doug can move the unaffected leg freely.



(2) In Bryant's traction both legs are in traction at a 90-degree angle, and the child buttocks are raised off the mattress. The child's weight provides the counter traction. The child should not be pulled toward the bottom of the bed.

**20.** Ethel, age 14, is in a hip spica cast. To turn her correctly, the nurse should:

1. use the cross bar.
2. turn her upper body first and then turn the lower body.
3. logroll her.
4. tell her to pull on the trapeze and sit up to help in turning.

(3) The client in a hip spica cast should be turned as a unit. The stabilizing bar should not be handled.

**21.** An infant is being treated for congenital hip dysplasia with a Pavlik harness. The baby's mother asks whether she can remove the harness if it becomes soiled. The best response for the nurse to make is:

1. "No, the harness may not be removed."
2. "No, she will only be wearing it a few days."
3. "Yes, just long enough to clean the area."
4. "Yes, just overnight while she sleeping."

(1) The harness is not to be removed until the hip is stable with 90 degrees of flexion and x-ray confirmation. This usually occurs after about 3 weeks in Pavlik harness.

**22.** An elderly woman had an Austin-Moore prosthesis inserted following an intracapsular hip fracture. During the postoperative period, the nurse teaches the client about maintaining her hip in the proper position. Which of the following statements indicates that the client understands her instructions?

1. "I shouldn't bend my knees."
2. "Put a pillow between my legs when you turn me."
3. "I will be sure to put my shoes on when I go for a walk."
4. "Put me on the commode chair for my bowel movement."

(2) A pillow placed between the client's legs will keep the affected leg abducted and in good alignment while the client is being turned. The unaffected knee may be bent. The client should not bend to put her shoes on until the physician gives her permission to do so. Sitting on a commode chair would cause too great a flexion of the hip joint in the early recovery period. A raised toilet set would be needed.

**23.** The nurse is caring for an elderly woman who has had a fractured hip repaired. In the first few days following the surgical repair, which of the following nursing measures will best facilitate the resumption of activities for this client?

1. arranging for the wheelchair
2. asking her family to visit
3. assisting her to sit out of bed in a chair qid
4. encouraging the use of an overhead trapeze

(4) Exercise is important to keep the joints and muscles functioning and to prevent secondary complications. Using the overhead trapeze prevents hazards of immobility by permitting movement in bed and strengthening of the upper extremities in preparation for ambulation. Sitting in a wheelchair would require too great hip flexion initially. Asking her family to visit would not facilitate the resumption of activities. Sitting in a chair would cause too much hip flexion. The client initially needs to be in a low Fowler's position or taking a few steps (as ordered) with the aid of a walker.

**24.** When a child becomes a toddler with clubfeet (Talipes), the device that is used to maintain the feet in proper alignment is:

1. braces on both legs.
2. shoe on the opposite foot.
3. no more therapy is necessary at this stage.
4. no running until age 4.

(2) Putting shoe on the opposite foot provides a constant pulling tension to maintain proper alignment.

**25.** Assisting a blind person to navigate safely, the nurse would:

1. hold a patient's arm and push forward.
2. walk side by side, holding the hand.
3. allow a blind person to hold the nurse's arm and walk slightly behind.
4. allow the patient to walk in front of the nurse.

(3) Other senses are amplified when one sense is lost; a blind person can sense muscle tension indicating movement from holding the nurse's arm.

**26.** A patient presents at the emergency room with a dull, constant flank pain suggestive of renal calculi. Appropriate discharge teaching from the patient would include:

1. maintain regular exercise pattern.
2. increase fluid intake to maintain urine output.
3. decrease fluid intake to prevent movement of calculi.
4. take vitamin C and calcium supplements to increase urine acidity.

(2) Fluid 2000 cc or more will be needed to help flush the stone out of the renal system. All urine should be passed through a strainer as to collect the stone for examination, which may have dieting implications for the patient.

**27.** In evaluating the lab work of a patient in hepatic coma, which of the following lab tests will be most important?

1. blood urea nitrogen
2. serum calcium
3. serum ammonia
4. serum creatinine

(3) When a patient is in hepatic coma, he is in liver failure. The liver can no longer metabolize amino acids completely, thus ammonia levels increase causing brain tissue irritation.

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

1. measure intake and output.
2. check albumin level.
3. monitor glucose levels.
4. increase enteral feeding.

(1) It is important to measure intake and output, which should equal. Enteral feeding are hyperosmotic agents pulling fluid from cells into vascular bed. Water given before feeding will present a hyperosmotic diuresis. I and O measures assess fluid balance.

**29.** A patient post-operative abdominal surgery has a nasogastric tube in place. The purpose of this tube immediately following surgery is to:

1. simplify medication administration.
2. measure accurate input and output.
3. prevent accumulation of fluids and gas.
4. facilitate collection of specimen.

(3) Immediate post-op abdominal surgery, an Ng tube keeps the stomach (decompressed) to prevent surgical sites disruption and fluid loss through gastric vomiting of gas and fluid.

**30.** In caring for a client with an Ng tube, which of the following solutions should be used to irrigate the tube Q shift to maintain patency?

1. 0.9 percent saline
2. 0.25 percent saline
3. distilled water
4. warm tap water

(1) Normal saline is used to irrigate the Ng tube as it does not reach other electrolytes from the stomach.

**31.** An 80-year-old aphasic CVA client had abdominal surgery two days ago. Which of the following places is this client at the highest risk for inadequate pain management?

1. inability to turn, cough, and deep breath
2. inability to communicate pain
3. inability to ambulate freely
4. inability to use a bedside commode

(2) The patient cannot speak to alert one to his pain state. The nurse will need to provide alternate methods of communication with the patient.

**32.** A patient is to have an enema to reduce flatus. The enema tube should be inserted:

1. 4 inches.
2. 6 inches.
3. 2 inches.
4. 8 inches.

(1) Enema tubing must be passed beyond the internal sphincter. Two inches is not long enough to pass the internal sphincter. Six to eight inches are too long and may cause bowel trauma.

**33.** A patient with cirrhosis of liver presents with ascites. The physician is to perform a paracentesis. For safety, the nurse should ask the patient to:

1. drink 1000 cc prior to the procedure to affect fluid loss.
2. eat foods low in fat.
3. empty the bladder prior to the procedure.
4. assume the prone position.

(3) When performing a paracentesis, safety requires that the patient be sitting up for the fluid to settle to lower abdomen. To prevent trauma to the bladder while inserting needle to aspirate fluid, the bladder must be empty.

**34.** A patient is scheduled for abdominal surgery and is ordered Neomycin. Neomycin is given to prevent formation of:

1. ammonia.
2. urea.
3. hemoglobin.
4. bile.

(1) Neomycin is given to sterilize the bowel by decreasing normal intestinal bacteria, which produces ammonia.

**35.** A patient is admitted with cirrhosis of the liver. He starts to vomit a reddish fluid. The nurse should anticipate the need for which type of tube insertion?

1. Salem Sump
2. Levine
3. Miller Abbott
4. Sengstaken Blakemore

(4) Sengstaken Blakemore is a lumen tube used with ruptured esophageal varices. One opening drains the stomach; second opening is a balloon tube that when inflated will compress the bleeding vessels; and third is to maintain pressure. These tubes are usually managed in ICUs and for no longer than seventy-two hours.

**36.** The position of comfort for a patient following removal of an appendix is:

1. supine.
2. prone.
3. semi-Fowler's.
4. Sims' position.

(3) Semi-Fowler's positioning is used to prevent stretching and irritating muscles and incision site. Flexion position decreases the tension over the surgical site.

**37.** Acute appendicitis is a condition associated with:

1. portal hypertension.
2. compromised circulation to appendix.
3. poor dietary habits.
4. bowel infections.

(2) Appendicitis is an inflammation of the appendix caused by either obstructive fecalith or decreased circulation to the appendix.

**38.** The pathological process causing esophageal varices is:

1. ascites and edema.
2. systemic hypertension.
3. portal hypertension.
4. dilated veins and varicesitis.

(3) Esophageal varices results from increased portal hypertension. In portal hypertension, the liver cannot accept all of the fluid from the portal vein. The excess fluid will back flow to the vessels with lesser pressure, such as esophageal veins or rectal veins causing esophageal varices or hemorrhoids.

**39.** A patient is diagnosed with colitis. Which of the following complications of colitis is more serious?

1. perforation
2. ileus
3. bleeding
4. obstruction

(1) Bowel in colitis is very friable, which predisposes risk of perforation leading to peritonitis. A patient with colitis does have bleeding but not as great a risk as perforation.

**40.** Crohn's disease is to ulcerative colitis as:

1. bleeding : no bleeding.
2. 10 stools : 6 stools.
3. 6 stools : 10 stools.
4. no bleeding : bleeding.

(3) Patients with Crohn's and ulcerative colitis both have loose stools. Area of pathology influences the number of stools per day. A patient with Crohn's disease has 4–6 stools per day, whereas a patient with ulcerative colitis has 10 stools per day. Both conditions may have blood in the stools.

**41.** In preparing a patient for a colonoscopy, the nurse teaches him to take phospho soda one day before the procedure. Phospho soda is classified as:

1. an emollient.
2. a saline cathartic.
3. a stimulant.
4. a bulk forming agent.

(2) Phospho soda is a concentrated saline cathartic that acts as an irritant in the intestines promoting evacuation.

**42.** In teaching a patient with Hepatitis A how to prevent reoccurrences, the nurse should emphasize:

1. washing her clothes separately.
2. washing dishes in hot water.
3. washing hands frequently.
4. dispose of tissue properly.

(3) Hepatitis A is a fecal-oral transmission route. The best way to prevent Hepatitis A occurrences is to teach everyone good hand-washing techniques, especially after using the bathroom.

**43.** Which of the following Hepatitis has *no* carrier state, as it cannot be transmitted from person to person?

1. hepatitis A
2. hepatitis B
3. hepatitis C
4. hepatitis D

(1) Hepatitis A is the only Hepatitis, when once resolved no longer has a carrier state; transmittable to others through blood. Remember Hepatitis A is a fecal oral transmitted route, not blood/secretions borne.

**44.** A patient presents with bright red vomit. A nasogastric tube insertion with lavage is ordered. To insert the Ng tube, the nurse will position the patient in the:

1. supine position.
2. prone position.
3. high Fowler's position.
4. Trendelenberg position.

(3) This position offers the best approach for entry into the esophagus and uses gravity to aid in passage. With high Fowler's, the head flexes slightly forward partially occluding the trachea making passage easier into the esophagus.

**45.** In administering an Ng tube feeding slowly, the nurse reduces the hazard of:

1. abdominal pain.
2. regurgitation.
3. flatulence.
4. distension.

(2) Regurgitation may occur following rapid inflow of feeding due to the cardiac sphincter being opened by the Ng tube presence. Normally the cardiac sphincter closes after eating, preventing regurgitation of food or acid reflux.

**46.** Duodenal ulcer is to a gastric ulcer:

1. food relieves pain : food causes pain.
2. food causes pain : food relieves pain.
3. food does not affect pain : food decreases pain.
4. food increases pain : food does not affect pain.

(1) With peptic ulcer dz, food does not play a role. If the ulcer is gastric, food intake causes the patient more pain related to hydrochloric acid release. Patient with gastric ulcers has less pain if they do eat. With duodenal ulcers, the patient will wake up in the night with pain, eat, and be free of pain. For a duodenal ulcer patient, food relieves pain.

**47.** Patients receiving Ng tube feedings most commonly experience diarrhea due to:

1. high osmolarity of the feeding.
2. inappropriate positioning.
3. bacterial contamination.
4. higher fiber content of the feeding.

(1) Tube feedings are hyperosmolar, drawing more water into the bowel, causing dehydration and diarrhea. Water between or after Ng tube feedings will decrease hyperosmolar diarrhea. Today, many tube feedings are set up with water flush bags to the pump, thus assisting the diarrhea problem.

**48.** A patient with GERD (gastro-esophageal reflux disease) is having difficulty sleeping at night. Which of the following interventions will help lessen the effect of GERD (acid reflux)?

1. Elevate the head of the bed on 4–6 inch blocks.
2. Lie down after eating.
3. Increase fluid intake just before bedtime.
4. Wear a girdle.

(1) Elevation of the head of the bed allows gravity to assist in decreasing the backflow of acid into the esophagus. Fluid does not flow uphill. The other three options all increase fluid backflow into the esophagus through position or increasing abdominal pressure.

**49.** In assessing a client for gastritis, the client's history would show consumption of:

1. pro banthine.
2. nonsteroidal anti-inflammatory drugs (NSAIDS).
3. aquamephyton.
4. synkavite.

(2) NSAIDS (ibuprofen or Celebrex) are medications known to cause gastritis. They should be taken with food to decrease the incidence of gastritis.

**50.** A patient with dumping syndrome should \_\_\_\_\_, but a patient with GERD should \_\_\_\_\_.

1. sit up 1 hour after meals; lie flat 30 minutes after meals
2. lie down 1 hour after eating; sit up at least 30 minutes after eating
3. sit up after meals; sit up after meals
4. lie down after meals; lie down after meals

(2) Patients with dumping syndrome should lie down after eating to decrease dumping syndrome. GERD patients should sit up to prevent backflow of acid into esophagus.

**51.** What type of nurse specialist helps patients return to/and maintain maximum functioning, a sense of well-being, and independence?

1. orthopedic
2. neurological
3. psychiatric
4. rehabilitation

(4) The rehabilitation nurse is in the best position to help the patient return to his/her ADLs in the best possible condition.

**52.** An elderly female patient fell and fractured her hip and has degenerative arthritis in both knees. What nursing diagnosis is most appropriate for this patient?

1. activity intolerance
2. pain
3. impaired physical mobility
4. risk for injury

(3) The integrity of the bone structure has been compromised leading to impaired physical mobility.

**53.** Which of the following is the most common cause of congenital spinal deformity?

1. scoliosis
2. spina bifida
3. meningocele
4. Myles meningocele

(1) Scoliosis is a curvature affecting primarily females that have a congenital pattern in families.

**54.** A patient needs range of motion exercises while she is bedridden. What type of exercises are these?

1. isokinetic
2. isometric
3. muscle toning
4. isotonic

(4) ROM exercises are isotonic in that they maintain muscle tone at its current level by having a consistent muscle tension, contraction, and movements.

**55.** A patient is having problems with her ankles. To assess her ankles' ROM, which ROM exercises will the nurse have her do?

1. flexion, extension, and hyperextension
2. flexion, extension, abduction, and adduction
3. external rotation and internal rotation
4. extension, flexion, inversion, and eversion

(4) Moving a joint through the full range of motion identifies limitation of movement.

**56.** Pulling is easier than pushing, so pull your patient toward you rather than pushing them. This can help reduce which of the following?

1. reduces workload
2. decreases opposition from gravity
3. maintains stability
4. prevents muscle strain

(1) Pulling an object works with gravitational force not opposing gravity, thus lowering risk of muscle strain.

**57.** You are transferring a patient from a wheelchair to the bed. You should:

1. pull the patient toward you, pivot on unaffected limb.
2. pull the patient toward you, pivot on the affected limb.
3. push patient towards the bed, pivot on the affected limb.
4. stand patient on both legs and push toward the bed.

(1) Pulling the patient toward the nurse will lower the workload force. Pivoting on the unaffected leg offers strength to support the affected limb while pivoting to the bed.

**58.** A patient with rheumatoid arthritis of the wrist will have mobility problems with:

1. dorsiflexion.
2. finger extension.
3. hypotension.
4. circumduction.

(1) Normal wrist movement includes dorsiflexion extension, abduction, and adduction. With exercise changes in wrist, apices is narrowed, and dorsiflexion is decreased.

**59.** Spinal changes occurring with pregnancy that alter mobility is:

1. scoliosis.
2. kyphosis.
3. lordosis.
4. ankylosing spondylitis.

(3) The spinal change occurring with pregnancy is lordosis. This occurs due to the enlarging uterus and the affect of gravity.



**60.** Physical examination of the patient regarding mobility should begin with:

1. gait.
2. oriented to time, place, and person.
3. Romberg test.
4. Tandum walk test.

(1) Gait is usually assessed as the patient walks into the room. Gait is smooth flowing, rhythmic without assistive devices.

**61.** You are charged with turning a client who has a fractured hip. You will avoid which position for the fractured hip?

1. abduction of the hip
2. adduction of the hip
3. flex the hip at 80 degrees flexion
4. flex the hip at 90 degrees

(2) New prosthetic hips should have an abduction pillow in place to avoid adduction.

**62.** Which assessment of the immobilized client would prompt the nurse to take further action?

1. client complaining of fatigue
2. urinary output of 50 ml per hour
3. white blood cell count of 9.5
4. absence of bowel sounds

(4) Immobility causes decreased peristalsis leading to ulcers characterized by absence of bowel sounds. Fatigue is a complaint that any client may experience in the hospital. Urinary output is within normal range as well as the white count. Absence of bowel sounds is a complication of immobility. It could be followed by constipation and other gastrointestinal problems.

**63.** A client who has been immobilized for an extended period questions the need for a tilt table. The nurse explains that the tilt table is used to help:

1. prevent hypertension.
2. encourage increased activity.
3. encourage circulation to the skin.
4. prevent loss of calcium from long bones.

(4) Calcium leaves the long bones during period of prolonged bed rest. The tilt table places the client in the upright position, which provides for weight bearing.

**64.** The nurse is determining ROM in a client. The nurse moves the patient's leg out and away from the midline of the body. What movement does the nurse document?

1. extension
2. flexion
3. abduction
4. adduction

(3) Movement away from the body or midline is called abduction.

**65.** A patient complains that she has gotten shorter over the last 10 years. The nurse explains to the patient that she has a musculoskeletal disorder called:

1. osteoporosis.
2. scoliosis.
3. osteopenia.
4. lordosis.

(1) Osteoporosis is characterized by a decrease in bone density in females postmenopausal. As there is loss of bone of the spine, the height is lost.

**66.** The patient is being taught about life style changes necessary for her condition, osteoarthritis. Which of the following changes will most likely reduce the signs and symptoms of osteoarthritis?

1. avoiding exercise
2. restricting caffeine
3. abstaining from alcohol
4. reducing weight

(4) DJD (Degenerative Joint Disease) is a condition caused by wear/tear of the joints. Excessive body weight is a risk factor associated with the development and progression of arthritis. Avoid aggravating activities such as not climbing stairs. Caffeine has no affect on osteoarthritis. Alcohol intake is not relevant to osteoarthritis.

**67.** A client has a cast placement for a left fractured radius. The nurse suspects compartment syndrome if the client expresses pain that:

1. intensifies with left arm elevation.
2. disappears with left arm flexion.
3. increases with the arm in a dependent position.
4. radiates up the arm to the left scapula area.

(1) Unrelenting pain is the most common symptom of compartment syndrome. The pain is the result of ischemia. Elevating the limb further reduces circulation, worsening the ischemia, and further intensifies the pain.

**68.** The nurse would expect to develop crepitus in a patient with osteoarthritis of the knee during which health assessment technique?

1. palpation
2. percussion
3. auscultation
4. inspection

(1) Crepitus is a grating sensation associated with loss of cartilage in degenerative joint disease. Crepitus is best detected by palpation of affected joint.

**69.** In evaluating a patient for osteoarthritis of the hands, you will document the finding of:

1. dry, wrinkled skin.
2. Heberden's nodes.
3. Olecranon nodules.
4. metacarpal joint enlargement.

(2) Heberden's nodes are classical findings associated with hand osteoarthritis. OA affects the distal interphalange joints. "Knots" or nodules appear in the furthest joints of the fingers, causing stiffness and decreased mobility.

**70.** In assessing a 75-year-old female who fell, causing a force fracture of the hip, you would expect to find:

1. no swelling.
2. longer limb on affected extremity with internal rotation.
3. limbs of equal length.
4. shortened extremity of the affected limb with external rotation.

(4) Following a fracture, muscle spasm causes the nonintact limb to slide over each other causing affected leg to be shorter and roll outward.

**71.** The most important assessment intervention in caring for a patient with a fractured limb is:

1. providing a trapeze bar to promote self-movement.
2. providing passive ROM of unaffected limb.
3. assessing circulation and sensation of affected limb.
4. auscultating limb to detect early pneumonia.

(3) The most important check is for compromised circulation and neurologic impairment of affected extremity; unaffected limb patient should perform active ROM.

**72.** The importance of forcing fluids with an immobilized patient is to:

1. prevent pneumonia.
2. prevent urinary stasis.
3. prevent skin breakdown.
4. maintain peristalsis.

(2) Adequate fluid intake will flush the kidneys and prevent urinary stasis. Preventing urinary stasis further decreases the risk of UTIs and renal calculi.

**73.** A patient is complaining of back pain with radiating pain down the left leg. You suspect a herniated nucleus pulposus (HNP). Which of the following tests would be most beneficial to the patient?

1. myelogram
2. x-ray of spine
3. complete blood count
4. liver function studies

(2) X-rays will show narrowing of disk spaces as in HNP. Myelogram shows compression of the spinal cord. CBC and LFT are not pertinent to the evaluation for HNP.

**74.** In turning a new post-op patient who has had a L4 laminectomy, safety demands logrolling with \_\_\_\_\_ number of nurses.

1. 1
2. 2
3. 3
4. 6

(3) New spinal cord surgery demands no bending or twisting of surgical site. Three nurses are required: one to help with head/neck, one to help with hips, and another to help with lower extremities to prevent twisting of the back. One or two people do not provide support for logrolling technique. Six people would not have enough room to work properly.

**75.** A patient with a laminectomy is being discharged. You will teach him to most definitely avoid which of the following positions?

1. supine
2. prone
3. Sim's
4. lateral

(2) Prone position is to be avoided as it allows gravitational pull on new surgical incisions. Prone position does not offer firm support to the spine. Supine position offers firm support to the back. Sim's or lateral are both side-lying positions in which the back can be kept straight until healed.

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

1. calling the physician for an increased dosage of pain medication.
2. calling the physician for a sedative.
3. referring the client for a psychiatric consult.
4. developing interventions for grief and loss.

(4) The client's pain is affective as well as sensory. Grieving his wife's death is a normal response that does not necessarily require psychiatric consult. Options 1 and 2 address the sensory, nonaffective component of his pain.

**77.** Patient education by the nurse entails:

1. telling the patient everything about the disease, what is happening in the course of the disease, and the outcome.
2. giving information to the patient that is accurate and understandable.
3. telling the patient that the pain they experience may not be real.
4. giving the patient pain medication when it is experienced.

(2) Patient education entails giving the patient accurate and understandable information and emphasizing pain management interventions. Also, the patient should be involved in their pain management.

**78.** Distraction Theory in Pain management:

1. focuses one's attention on other stimuli rather than the pain.
2. is cognitive reappraisal.
3. replaces positive images of pain with other images.
4. uses medication.

(1) The focusing is on the positive stimuli rather than the negative input. Using a distractor, for example music, rather than focusing on the fears, myths, or pain itself.

**79.** Relief of muscle pain, spasms, and tension by the nurse should consist of:

1. having the client continue the same activity as usual.
2. immobilizing the client.
3. applying hot or cold, pressure or vibration to the client.
4. giving as much pain medication to ease the muscle.

(3) Application of superficial heat and cold, massage, pressure, or vibration, should be offered to alleviate pain associated with muscle tension, pain, or spasms.

**80.** Nonpharmacological management involves all of the following except:

1. hypnosis alone.
2. psychological care including support groups.
3. physical and psychological modalities.
4. pain-reducing drugs only.

(4) All physical and psychosocial therapies can be used concurrently with drugs and other modalities to manage pain. These interventions can be carried out by the nurse with the client and family.

**81.** The nurse is using cognitive-behavioral methods of pain control and knows that the client will do all of the following except:

1. will not do well with this technique.
2. will benefit by restoring the client's sense of self-control.
3. will help the client in controlling symptoms.
4. will help the client have active participation in own care.

(1) These interventions (strategies) will help the client in all areas of client well-being. Focusing on perception and thought, cognitive techniques are designed to influence how one interprets events and bodily sensations.

**82.** Simple relaxation exercises include:

1. slow rhythmic breathing.
2. recalling all past events and experiences.
3. playing games that require thinking.
4. running a race.

(1) Slow rhythmic breathing; simple touch, massage, or warmth; peaceful relating of pleasant past events or experiences; and listening to favorite music.

**83.** Chronic pain is a significant problem for many senior citizens. Nonpharmacological approaches should be an integral part of their healthcare plans. The reason(s) these approaches are particularly good for this age group is (are):

1. this age group suffers more chronic pain than the younger age groups.
2. these healthcare interventions carry minimal risks or adverse effects.
3. senior citizens need to use every distraction possible because of their years.
4. medications will make seniors more disoriented.

(2) For seniors the use of nonpharmacological approaches could enhance their management of pain with less side effects or adverse reaction.

**84.** Aromatherapy will:

1. cure the disease when related to the upper respiratory system.
2. enhance apitherapy.
3. reduce stress, promote relaxation.
4. reduce pregnancy complications.

(3) Aromatherapy is believed to have relaxing effects, both mental and spiritual, on the individual. Curative effects have not been scientifically proven. Apitherapy are products derived from honeybees and have been therapeutically used. Aromatherapy is contraindicated in pregnancy and may trigger complications.

**85.** Nurse practitioners relate that older people respond especially well to overall energizing effects of magnetic field for chronic pain. Some of the education that is necessary before using this therapy is:

1. all children and adults can use this therapy without harm.
2. this therapy can be used on the abdomen all the time.
3. patients with pacemakers or defibrillators can have the magnets anywhere on their body.
4. warn patients to remove all magnets before surgery.

(4) Warn patients to remove all magnets before surgery because magnets may cause life-threatening instrument malfunction. People with pacemakers or defibrillators should not be placed closer than 6 inches (15 cm) to such devices to avoid interfering with their function; this therapy is not recommended for children under age 5 or for pregnant women. The magnets should be avoided on abdomen 60–90 minutes after meals.

**86.** Pain is primarily a:

1. protective mechanism as well as a complex for biopsychosocial phenomenon.
2. an emotional response as a part of aging.
3. a single disorder with a single component of neuropathic symptoms.
4. an emotional response to a decrease intensity.

(1) Pain is primarily a protective mechanism, but it is also a complex biopsychosocial phenomenon. It is also a single disorder that has components of both nociceptive and neuropathic pain. Pain is not a normal part of aging.

**87.** Visceral pain is:

1. an unpleasant response.
2. anything that is bodily generated.
3. well localized, usually from bone or spinal metastases or injury to cutaneous or deep tissue.
4. primarily afferent fibers that initiate the experience, stimulated by tissue damage.

(3) Well localized, usually from bone or spinal metastases or from injury to cutaneous or deep tissue.

**88.** In the frail elderly, the most sensitive indicator of pain may be which of the following?

1. crying out in pain
2. moaning
3. an observed decrease in the client's usual level of functioning
4. facial grimacing

(3) An observed decrease in the client's usual level of functioning.. The other areas such as crying, moaning, and facial grimacing can be related to cultural norms, religious beliefs, or psychosocial modifiers.

**89.** The nurse who is assessing for physiological evidence of anxiety in a client would look for:

1. bradycardia.
2. excessive salivation.
3. constricted pupils.
4. urinary frequency.

(4) Urinary frequency is probably the beginning sign of anxiety; tachycardia, increase respirations, usually accompanies this symptom.

**90.** If a client with anxiety also has an illness-related loss of control over physical integrity, the most appropriate diagnosis in this situation would most likely be:

1. ineffective individual coping.
2. altered thought processes.
3. sensory-perceptual alterations.
4. ineffective denial.

(1) Although acute pain and chronic pain are obvious nursing diagnoses for the person in pain, assessment may indicate that the client has other related problems—for example, ineffective coping or anxiety.

**91.** The nurse would formulate which of the following expected outcomes to measure whether a client has experienced a reduction in anxiety?

1. use of problem-solving skills
2. identification of stressors associated with anxiety
3. reduced tension, irritability, tremors, and sweating
4. participation in decision making

(3) Reduced tension, irritability, tremors, and sweating. The overall goal is for the client to seek interventions that maximize his or her anxiety relief and quality of life.

**92.** The nurse would offer which of the following forms of complementary therapy as a means of offering hope and decreasing feelings of aloneness in client?

1. relaxation
2. music therapy
3. spiritual support
4. touch therapy

(3) The nurse needs to explore emotional factors (feelings) of the client show compassion and understanding, if we are to be able to minister to our clients needs. Spiritual distress is met through the encouragement and preservation of life coupled with the belief that every human life does have meaning; that no one ever lives, suffers, or dies in vain.

**93.** The nurse who assesses energy fields and uses appropriate interventions to modulate and balance the energy field is using which of the following forms of complementary therapy?

1. relaxation
2. music therapy
3. spiritual support
4. touch therapy

(4) Therapeutic touch incorporates the nursing process, beginning with assessment and continuing through diagnosis treatment and evaluation. The technique is best known for its ability to relieve pain and anxiety.

**94.** The main benefit of therapeutic massages is:

1. to help a person with swollen legs to decrease the fluid retention.
2. to help a person with duodenal ulcers feel better.
3. to help damaged tissue in a diabetic to heal.
4. to improve circulation and muscles tone.

(4) Particularly in the elderly adults, therapeutic massage will help improve circulation and muscle tone as well as the personal attention and social interaction that a good massage provides. A massage is contraindicated in any condition where massage to damaged tissue can dislodge a blood clot.

**95.** The nurse who is working with a client who is having trouble sleeping might use the following alternative therapy:

1. acupuncture.
2. rolfing.
3. meditation.
4. herbal drugs.

(3) Meditation is a systematic and continued focusing of the attention on a single target perception, continually holding a specific attention set. Meditation can access the relaxation response.

**96.** A technique used by women during labor for either no medications or decreased medical interventions is:

1. hypnosis.
2. herbal.
3. homeopathy.
4. ayurvedic.

(1) The technique of hypnosis can be done either alone or with another person; consisting of breathing patterns or distractions away from the labor discomfort(s); also focusing on a distractor is common, for example, major methods such as language, read.

**97.** Nutritional input impacts the body in multiple ways. Major illnesses that have been studied extensively that may be affected by diet are:

1. cardiovascular disease and hepatitis.
2. cardiovascular disease and asthma.
3. cancer and cardiovascular disease.
4. skin disease and thyroid disease.

(3) Nutritional guidelines have been developed that have been proven beneficial for an individual in possible prevention of cardiac disease and cancer.

**98.** Complementary therapies are being used by people because:

1. they want to help medical practice to change.
2. they believe in the importance and value of one's inner life and experiences.
3. they believe if nurses were primary healthcare providers, they can do anything complementary therapy desired.
4. they distrust everybody and want to only use food grown by themselves.

(2) Alternative medicine or complementary therapy have many variables that are significant to the individual as to why they use these therapies versus conventional therapy, (for example, distrust of healthcare system); "this promotes health rather than focusing on illness." "I feel better"; "more holistic approach to healthcare."

**99.** The National Institutes of Health (NIH) has categorized alternative modalities and therapies into seven fields of practice. Some of them are:

1. mind/body or behavioral interventions and osteopathic interventions.
2. medical/nursing interventions and hybrid medicine.
3. herbal medicine and pharmacologic and biologic treatment.
4. diet, nutrition, and lifestyle changes with drugs and vaccines added.

(3) The seven fields of practice are categorized as: herbal medicine; diet, nutrition, and lifestyle changes; mind, body, or behavioral interventions; alternative methods; bioelectromagnetics; pharmacologic and biologic treatments.



**100.** As a nurse one should know about alternative therapies. The reason(s) is (are):

1. knowledge of the therapy will allow the client to use it.
2. knowledge of the therapy will help the nurse to use the nursing process in working with a client who wishes to use this method.
3. knowledge tells the nurse that the client is always correct in what they want to use.
4. knowledge gives the client time to begin a therapy.

(2) Professional nurses need to have a knowledge of alternative therapies, use the nursing process in evaluating appropriateness for the individual as well as the responsibility for safe practice.

**101.** Which of the following is an appropriate goal of nursing care for a client at risk for nutritional problems?

1. Provide oxygen.
2. Promote healthy nutritional practices.
3. Treat complications of malnutrition.
4. Increase weight.

(2) Promoting healthy nutritional practices incorporates both categories of undernutrition and overnutrition. Option 1 is incorrect because it reflects an intervention, not a goal statement. Option 3 is incorrect because it reflects a therapeutic treatment. Option 4 is incorrect because weight gain would only be an appropriate goal if the client is underweight, and there is not enough information to determine this.

**102.** The nurse would explain to a client who underwent gastric resection that which of the following meals is most likely to cause rapid emptying of the stomach?

1. a high protein meal
2. a high fat meal
3. a large meal regardless of nutrient content
4. a high carbohydrate meal

(4) Meals that are high in carbohydrates promote rapid gastric emptying. The other options are associated with decreased transit time and, therefore, meals of these types remain in the stomach for a longer time.

**103.** Which of the following foods should be avoided by clients who are prone to develop heartburn as a result of gastroesophageal reflux disease (GERD)?

1. lettuce
2. eggs
3. chocolate
4. butterscotch

(3) Ingestion of chocolate can reduce lower esophageal sphincter (LES) pressure leading to reflux and clinical symptoms of GERD. All of the other foods do not affect LES pressure.

**104.** Which of the following foods would present a problem for a client diagnosed with celiac disease?

1. butter
2. oats or barley cereal
3. fresh vegetables
4. coffee or tea

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

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

1. pureed canned squash
2. pureed apples
3. yogurt
4. infant rice cereal

(4) Single grain infant cereals are recommended first because they are easily digestible and have added iron content. Option 3 is incorrect because yogurt is a milk product and introduction should be delayed until 12 months because of the risk of milk allergy. Options 1 and 2 are incorrect because fruits and vegetables are usually given following the introduction of cereals.

**106.** A pregnant client has congenital heart disease. The nurse would expect to see which alterations in this client's diet during pregnancy?

1. reduced calories and reduced fat
2. caffeine and sodium restrictions
3. decreased protein and increased complex carbohydrates
4. fluid restriction and reduced calories

(2) Caffeine may increase heart rate that is already stressed due to pregnancy. Sodium may cause fluid retention. Both may need to be restricted. The other answers are incorrect because calories, fat, and protein are not usually decreased due to the risk of nutrient deficiencies.

**107.** What would be an appropriate outcome for the nursing diagnosis of body image disturbances for a client with anorexia nervosa?

1. Client verbalizes knowledge of maintenance diet.
2. Client demonstrates assertiveness with family.
3. Client verbalizes body size accurately.
4. Client demonstrates control of obsessive behaviors.

(3) Part of the problem for anorexic clients is an altered view of their body appearance (visualizing themselves as being fat even when they are emaciated). Option 1 involves a knowledge deficit; option 2 involves possible resolution of family dynamic issues; option 4 involves psychological adaptation.

**108.** What type of diet should the nurse provide to help a client with major burns maintain a positive nitrogen balance?

1. high protein
2. high carbohydrate
3. low carbohydrate
4. low protein

(1) Clients with burns are hyper-metabolic and require increased protein levels in order to maintain a positive nitrogen balance. Options 2 and 3 are incorrect; carbohydrate levels will not help the client to meet this goal. Option 4 is incorrect, a client with major burns requires a high-protein diet.

**109.** As part of the teaching plan for a client with type 1 diabetes mellitus, the nurse should include that carbohydrate needs may increase when:

1. an infection is present.
2. there is an emotional upset.
3. a large meal is eaten.
4. active exercise is performed.

(4) Active exercise increases insulin sensitivity, thus lowering blood glucose levels. Additional carbohydrates may be needed to balance the usual insulin dose. All of the other options will increase blood glucose levels.

**110.** The nurse is reviewing a client's lipid profile, including levels of high-density lipoproteins (HDLs), low-density lipoproteins (LDLs), and very low-density lipoproteins (VLDLs). The nurse concludes that the client has the desired pattern of results if the laboratory values show:

1. high HDL, low LDL, low VLDL.
2. low HDL, high LDL, high VLDL.
3. low HDL, low LDL, low VLDL.
4. high HDL, high LDL, high VLDL.

(1) High HDL levels are associated with reduced risk for coronary artery disease (CAD) and are thought to be cardio-protective. Decreased LDL and VLDL levels are associated with reduced risk for CAD. Increased levels of LDL and VLDL are associated with increased risk for CAD as are low HDL levels.

**111.** What would be the priority assessment for a female client reporting increased appetite, no weight gain, and a recent history of nausea and mild abdominal pain?

1. Refer the client to the emergency room for prompt treatment and management of symptoms.
2. Obtain weight and vital signs (VS) to establish client baseline
3. Place the client on a BRAT diet until the nausea subsides.
4. Ask the client whether she has experienced any changes in activity or fatigue level.

(4) A client who presents with these complaints may be experiencing a thyroid disorder—namely hyperthyroidism. It is important to obtain information relative to activity or fatigue level as this may help to direct further assessment. Option 1 is incorrect; there is nothing to suggest that the client is experiencing an acute problem that requires immediate intervention. Option 2 is a possibility because baseline VS and weight are needed to support a clinical diagnosis, but they are not the priority assessment at the present time. Option 3 is incorrect; the client has other symptoms that require attention. Placing a client on a BRAT diet is indicated for those clients with gastrointestinal upset (nausea, vomiting, and diarrhea) who are unable to maintain adequate hydration through normal eating patterns. There is nothing to suggest that this client requires this specific intervention at this time.

**112.** A client being treated for gout is being evaluated for compliance with diet therapy. Which of the following meal selections would indicate that the client has adhered to the diet plan?

1. scrambled eggs, white toast, and coffee
2. seafood casserole, wheat roll, and soda
3. pizza with anchovies and soda
4. braised liver, lentils, green peas, and tea

(1) Scrambled eggs, white toast, and coffee are all foods that are low in purine content. A client who is being treated for gout should restrict dietary purine sources because they can lead to an exacerbation of the disease process. All of the other options reflect dietary selections that range from moderate to high purine content. If dietary education is successful, then the client would avoid/limit these food selections.

**113.** Which of the following could present a nutritional problem for a client diagnosed with scleroderma?

1. diarrhea and anorexia
2. alternating constipation and diarrhea
3. increased acid secretion
4. increased flexibility of the skin

(3) A client with scleroderma often suffers from increased acid secretion and esophageal reflux. This could pose a significant nutritional problem. Option 1 is incorrect; anorexia is not commonly associated with this disease process.

Option 2 is incorrect because alternating periods of constipation and diarrhea are usually seen in a client who is experiencing irritable bowel syndrome (IBS). Option 4 is incorrect; skin becomes hardened during this disease process.

**114.** A 28-year-old client is admitted to the unit with a relapse of multiple sclerosis (MS) and is experiencing constipation. The client asks what other methods besides using laxatives will help to relieve this clinical condition. How will the nurse respond to the client's concern?

1. Tell the client that any form of laxative therapy can lead to chronic constipation.
2. Have the client increase fluids and roughage in the diet.
3. Have the client increase range of motion (ROM).
4. Call the physician regarding an order for an enema.

(2) A client with MS is prone to developing both bowel and bladder dysfunction as a result of this progressive degenerative neurological disease. Increasing fluids and roughage in the diet will help; to facilitate evacuation by improving stool consistency. Option 1 is incorrect; a general statement like this may cause more harm than good if it prevents use of stool softeners and suppositories that may be needed for a client with MS. Option 3 is incorrect because increasing ROM exercises does not directly address the issue of constipation. Increased mobility will help to increase peristalsis, but ROM exercises refer specifically to individual joint motion. Option 4 is incorrect because there is not enough clinical information provided to make this assessment. The nurse would have to assess further for elimination pattern and the date of the client's last BM.

**115.** A 60-year-old male client who has had COPD for 15 years is experiencing weight loss, despite insisting that he has been "eating a well-balanced diet." The nurse obtains a diet history and determines that the client has been consuming an adequate caloric intake of approximately 2,500 calories per day composed of 15 percent protein, 70 percent carbohydrates, and 15 percent fat. What recommendations would the nurse make regarding the client's weight status?

1. The client should maintain calories and increase the percentage of fat to 35 percent in the diet to promote weight gain.
2. The client should decrease the amount of fat in the diet and increase complex carbohydrates.
3. The client should merely increase his activity level as caloric intake and percentages of nutrients are adequate to sustain weight status.
4. The client should decrease carbohydrate content and increase calories, protein, vitamins, and minerals in order to prevent further weight loss.

(4) A client with COPD is often hypermetabolic from the disease process and requires increased calories, proteins, vitamins, and minerals in order to maintain desired weight and meet additional energy demands. Option 1 is incorrect; caloric intake is not adequate and increasing fat percentage to greater than 30 percent is not prudent. Option 2 is incorrect; increasing carbohydrates in the diet can lead to increased respiratory workload due to excess acid production. Option 3 is incorrect because increasing activity level will not help to prevent weight loss. In addition, the client may not be able to increase activity level due to effects of COPD.

**116.** Which of the following should be included in a plan of care for a client receiving total parenteral nutrition (TPN)?

1. Withhold medications while the TPN is infusing.
2. Change TPN solution every 24 hours.
3. Flush the TPN line with water prior to initiating nutritional support.
4. Keep client on complete bed rest during TPN therapy.

(2) TPN solutions should be changed every 24 hours in order to prevent bacterial overgrowth due to hypertonicity of the solution. Option 1 is incorrect; medication therapy can continue during TPN therapy. Option 3 is incorrect; flushing is not required because the initiation of TPN does not require a client to remain on bed rest during therapy. However, other clinical conditions of the client may affect mobility issues and warrant the client's being on bed rest.

**117.** A client is placed on a low residue diet. The nurse evaluates that the client understood dietary instructions given if the client states that she will refrain from eating which of the following favorite food items?

1. orange juice
2. baked potatoes
3. toasted white bread
4. milk

(4) Milk and milk products are limited in low-residue diets. All of the other diet selections can be used for this type of diet and indicate client understanding.

**118.** Which of the following diet elections would be appropriate for a client placed on a full liquid diet?

1. beef bouillon, cranberry juice, and tea
2. decaffeinated tea, gelatin, and popsicles
3. poached egg, coffee, and orange juice
4. plain yogurt and apple juice

(4) A full liquid diet contains all food items found on a clear liquid diet plus dairy products and prepared liquid formulas. Options 1 and 2 represent selections that are only found on a clear liquid diet. Option 3 represents a selection found on a low-residue diet.

**119.** Which of the following should be included in a plan of care for a client who is lactose intolerant?

1. Remove all dairy products from the diet.
2. Frozen yogurt can be included in the diet.
3. Drink small amounts of milk on an empty stomach.
4. Spread out selection of dairy products throughout the day.

(2) Clients who are lactose intolerant can digest frozen yogurt. Yogurt products are formed by bacterial action, and this action assists in the digestion of lactose. The freezing process further stops bacterial action so that limited lactase activity remains. Option 1 is incorrect; elimination of all dairy products can lead to significant clinical deficiencies of other nutrients. Option 3 is incorrect because drinking milk on an empty stomach can exacerbate clinical symptoms. Drinking milk with a meal may benefit the client because other foods, (especially fat) may decrease transit time and allow for increased lactase activity. Option 4 is incorrect because although individual tolerance should be acknowledged, spreading out the use of known dairy products will usually exacerbate clinical symptoms.

**120.** A client states that he is considering using herbal therapy as a natural source to aid in dietary health. What suggestions would you give to the client to assist with this decision?

1. "Herbal therapy treatments reflect standard doses so all similar products will provide the same biologic effect."
2. "Herbal therapy requires a prescription and may be an expensive treatment modality."
3. "It is important to inform your healthcare practitioner about your choice to start herbal therapy."
4. "Herbal therapy is a natural form of treatment with very few side effects."

(3) It is important to inform the healthcare provider at the start of herbal therapy, because this can prevent problems from potential drug interactions, verify indication for therapy, and acknowledge client's concerns over common complaints. It is critical for the client to read all labels in order to be an informed consumer. Even though there are standard products, herbal therapy ingredients can vary in different types of formulations. Option 2 is incorrect; no prescription is required, but herbal therapy can cause a financial burden to the client. Option 4 is incorrect; herbal therapy can cause side effects.

**121.** Which of the following is a realistic goal for an obese client (who is 5' 6" tall and weighs 250 lbs.) started on a weight loss program?

1. Maintain present physical activity level.
2. Eat only when hungry.
3. Demonstrate understanding of caloric intake, weight control, and physical activity.
4. Maintain an intake of 1,000 calories or less with 30 percent of calories from fat.

(3) It is important the client demonstrate an understanding of the basics of the treatment program, focusing on a multi-faceted approach of intake, physical activity, and weight control. Each of these is an interrelated variable that affects the client's ability to achieve and maintain weight control. Option 1 is incorrect because this may not be prudent (physical activity is usually increased). Option 2 is incorrect; it is not wise to utilize this feeding pattern because it may contribute to weight gain. Option 4 is incorrect; the total calories may be somewhat low, but the percentage of calories from fat is too high to effect substantial weight loss.

**122.** Which of the following problems can arise when a client taking anticoagulant therapy eats a large amount of garlic?

1. The garlic will assist in the coagulation process and accelerate clot formation.
2. None; garlic has no effect on blood coagulation.
3. None; garlic helps to support immune function.
4. Bleeding can occur because garlic inhibits platelet aggregation.

(4) Garlic is a food/herbal product that has long been recognized for its health benefits (lowers cholesterol/triglycerides, improves immune function, and decreases BP). Garlic can inhibit platelet aggregation and, therefore, prevents blood clot formation. A client who is taking anticoagulation therapy should be advised of potential interactions with excessive amounts of garlic in the diet. Option 1 is incorrect; there is an increased risk of bleeding. Option 2 is incorrect because garlic does indeed affect blood coagulation. Even though garlic does help to support immune function (option 3), this fact does not directly relate to anticoagulation therapy.

**123.** A high-fiber diet is thought to reduce the risk of colon cancer because it:

1. absorbs water from the intestinal wall.
2. promotes the excretion of bile.
3. stops diarrhea.
4. is low in kilocalories.

(2) High-fiber diets are recommended to reduce the risk of colon cancer, because fiber promotes bile excretion and speeds up intestinal transit time so that carcinogens are eliminated quicker.

**124.** Which recommendation would be appropriate for a client with congestive heart failure who requests dietary advice?

1. Recommend a low-potassium diet.
2. Recommend a 1000 cc fluid restriction.
3. Recommend a low-protein diet.
4. Recommend a 2–4 gram sodium diet.

(4) For the person in congestive heart failure, the diet recommended is a 2–4 gram sodium diet. This type of diet should allow the fluid as edema to be excreted from the extracellular compartment to the intracellular compartment and out of the body. Along with this, fluid intake should be increased as well as protein.

**125.** The most important ethical principle for the nurse to consider when a decision must be made whether or not to feed a client is:

1. the client's right to self-determination.
2. proportionality.
3. medical goals.
4. the client's quality of life.

(1) The most important ethical principle to consider is the client's right to self-determination. The client can decide whether they want to eat or not, usually based upon culture, religion, or other rational.

**126.** Which of the following nursing diagnoses would have the greatest likelihood of applying to a client receiving epidural morphine (Duramorph)?

1. risk for impaired skin integrity (pruritis)
2. ineffective airway breathing (tachypnea)
3. altered urinary elimination (polyuria)
4. altered nutrition, less than body needs (nausea)

(1) Pruritis, a rash, is a common side effect of epidural administration because of the histamine release.

**127.** Which of the following NSAIDS is most commonly used for a brief time for acute pain?

1. Advil
2. Aleve
3. Toradol
4. Bextra

(3) Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM, IV, or PO. Bextra is not strong enough.

**128.** A hospital discharge planning nurse is making arrangements for a client (who has an epidural catheter for continuous fusion of opioids) to be placed in a long-term care facility in the client's neighborhood to encourage family visiting. The facility has never cared for a client with this type of need. What would be the discharge planning nurse's best action?

1. Ask the physician for an extension of hospitalization until the epidural catheter is discontinued to allow for placement at the neighborhood facility.
2. Arrange for immediate inservices for the long-term care facility staff on pain management using epidural catheters.
3. Explain the situation to the client and family and seek another long-term care facility for discharge from the hospital.
4. Encourage the family to hire private duty nurses skilled in epidural catheter pain management to allow the client to be transferred to the neighborhood facility.

(3) Safety demands that a patient must be transferred to a facility that can deliver care equal to the hospital.

**129.** In managing nausea related to morphine epidural analgesia, the nurse would administer:

1. Indocin.
2. Codeine.
3. Motrin.
4. Compazine.

(4) A common side effect of morphine is nausea, vomiting, and rash.

**130.** The NSAID that is comparable to morphine in efficacy is:

1. Feldene.
2. Stodal.
3. Teradol.
4. Elavil.

(3) Teradol is the first injectable NSAID equal to morphine in efficacy.

**131.** Pain tolerance in an elderly patient with cancer would:

1. stay the same.
2. be lowered.
3. be increased.
4. no effect on pain tolerance.

(2) There is potential for a lowered pain tolerance to exist with diminished adaptative capacity.

**132.** In administering NSAID adjunctive therapy to an elderly client with cancer, the nurse must monitor:

1. BUN and creatinine.
2. creatinine and calcium.
3. Hgb and Hct.
4. BUN and CFT.

(1) Older adults may be more at risk for gastric and renal toxicity, which increases as adults age.

**133.** When administering a narcotic with a non-narcotic to relieve severe cancer pain, the nurse must remember:

1. this combination enhances pain relief.
2. this combination treats pain both centrally and peripherally.
3. the narcotic potentiates action of the non-narcotic.
4. each drug works in its own right.

(2) Using a narcotic with a non-narcotic treats both central and peripheral pain.

**134.** In evaluating the effectiveness of pain analgesia, the nurse should:

1. observe the patient's behavior.
2. ask the patient to reevaluate his pain status using the analog scale.
3. ask the family how the patient is feeling.
4. ask the patient to ambulate and re-evaluate gait

(2) Pain is a subjective phenomenon and can be evaluated only by the patient. Using an analog scale allows the patient to rate the pain from 0 (no pain) to 10 (excruciating pain). Pain should be assessed prior to analgesia and again 45 minutes post-analgesic administration.

**135.** In managing pain in an elderly client, the nurse should know:

1. pain is normal in aging and requires no management.
2. older adults are more sensitive to analgesics, requiring higher doses.
3. pain is not normal in aging and requires aggressive management.
4. in older patients, NSAIDS should not be used every two hours.

(3) Pain is not a normal aspect of aging, and it does require aggressive assessment management. NSAIDS can be used with caution in elderly, but if used renal function studies must be used to monitor function.



**136.** The nurse is evaluating her effectiveness in patient teaching regarding use of a PCA pump preoperatively. Which of the following statements indicates the need for further teaching?

1. The patient can describe the purpose of the PCA pump.
2. Observe the client administer his dose/simulation.
3. Patient states he must push the button to deliver the dosage.
4. Patient states his wife will be the one to push the button to deliver the dosage.

(3) Pain is a personal experience. The patient will be the only one to identify when he/she needs pain medication. The PCA pump allows the patient some control in managing the pain. The wife/husband cannot experience the patient's pain; thus, should not be pushing the button to administer medication.

**137.** A cancer patient has had a resurgence of severe acute pain. Which of the following routes of medication is most appropriate for this patient?

1. oral administration NSAIDS
2. oral administration of narcotics
3. rectal administration of NSAIDS
4. injectable pain reliever

(4) Injectables act more quickly than other routes and can relieve severe acute pain in one hour.

**138.** When administering morphine sulfate to a patient with chronic disease, the nurse's assessment reveals a respiratory rate of 12. The nurse's most appropriate action is to:

1. administer the medication and monitor closely.
2. withhold the medication and monitor closely.
3. administer the medication as morphine has no effect on respiratory status.
4. change the medication order to injectable Demerol.

(2) One of the most serious side-effects of morphine sulfate is respiratory depression. A respiratory rate of 12 or below should be a sign to withhold this medication until you can consult with the doctor.

**139.** The mechanism by which anxiety is modified in pain states that medication could have an additive effect to other pain relief measures is known as:

1. anticipatory guidance.
2. biofeedback.
3. cutaneous stimulation.
4. distraction.

(1) Anticipatory guidance is used to modify directly pain relief measures and adds to the effects of other pain relief measures. Distraction decreases stimuli, and the patient becomes unaware of pain. Biofeedback is a behavioral therapy that induces deep relaxation. Cutaneous stimulation of the skin helps to relieve pain.

**140.** The advantage of cutaneous stimulation in managing pain is that it:

1. costs less.
2. restricts movement and decreases.
3. gives client control over pain syndrome.
4. allows the family to care for the patient at home.

(3) Cutaneous stimulation allows the patient to have control over his pain and allows him to be in his own environment. Cutaneous stimulation increases movement and decreases pain.

**141.** Which of the following statements about the use of antidepressants with pain relief in cancer pain is true?

1. Antidepressants have no effect.
2. Antidepressants enhance the effect of analgesics.
3. Antidepressants decrease the effect of analgesics.
4. Antidepressants promote more rapid excretion of the medications.

(2) Antidepressants are useful adjuncts to analgesia in the management of cancer pain. The antidepressant potentiates or enhances the analgesics medication.

**142.** The medication of choice in treating neuropathic pain in chronic diabetes is:

1. Methlphenidrate (Ritalin).
2. Lidocaine.
3. Hydroxyine (Atarax).
4. Amitriptyline (Elavil).

(4) Elavil is a drug of choice for neuropathic pain in chronic diabetes mellitus. Lidocaine is a short-duration numbing medication. Atarax is a sedative drug. Ritalin is a stimulant, decreasing sedation.

**143.** Which of the following medications should be avoided in the elderly with renal insufficiency?

1. Morphine
2. Xycintin
3. Hydroxidone
4. Meperidine

(4) Meperidine has a biologically active ingredient not soluble and thereby increasing the toxicity risk (decrease in systemic clearance).

**144.** A home health nurse is preparing to apply a fentanyl (Duragesic) transdermal patch for pain management. Which of the following criteria would contraindicate the application of the patch to a client's upper arm?

1. The client had surgery on both upper arm areas.
2. The client has minimal hair distribution to this area.
3. The client has intravenous catheters placed in the hand.
4. The client uses an overhead trapeze bar for mobility.

(1) When a client has had surgery in an area where the patch is to be placed, healing and surgery of the area produces a site where poor circulation could be. The pain management patch would be better on an area in which the medication would give the best benefit.

**145.** The use of radiation therapy in the care of a patient with abdominal cancer would be:

1. to relieve metastatic pain as well as symptoms from local extension of primary disease.
2. to be a palliative treatment to relieve pain and maintain symptom control for the duration of the patient's life.
3. to be used alone as a therapeutic agent.
4. to help tissue to shrink and possible tumor eradication.

(2) Radiation therapy is a palliative treatment to relieve pain quickly, and treatment is tailored to the patient's clinical condition and prognosis (duration of life).

**146.** Which statement represents successful client teaching with regard to morphine administration via patient-controlled analgesia (PCA)?

1. "I will probably use less morphine this way than with taking injections in my hip."
2. "My family can push the button when I'm asleep so I will rest better."
3. "Using this device will keep me comfortable at all times."
4. "If I push the control button too often, I may get more medicine than needed."

(3) Use of the PCA pump gives the patient control of pain, even though a set amount of medication is put into the pump. Education of the patient and family is very important for the nurse to do.

**147.** In planning for pain control in a post-operative cancer patient, the nurse understands:

1. radiation therapy alone will be used.
2. noninvasive analgesic approaches should be tried before invasive palliative approaches.
3. never use radiation therapy, unless you are sure the patient will die.
4. radiation therapy is complementary to analgesic drug therapies.

(4) Both radiation therapy and analgesic drug therapies can be used together to enhance the effectiveness as they directly target the cause of pain.

**148.** What considerations should be noted by the nurse when pharmacological support is given for cancer patients having procedures?

1. The needs of the individual and the type of procedures to be done.
2. All children and adults should have heavy dosages of drugs.
3. All children no matter what age, should have hypnosis, distraction, imagery, and relaxation therapy.
4. No special considerations are necessary.

(1) The needs of the individual and the type of procedure to be done shape the pharmacological approach to managing procedure-related pain. Because children have special needs, the nurse's expertise and experience with children are key to successful therapy.

**149.** Cancer pain depends upon what?

1. the age of the patient and how much fear and anxiety is present
2. the type of cancer, the site of the cancer, and the time of the initial pain episode
3. the type of cancer, the stage of the cancer, and the threshold (tolerance for pain)
4. the psychosocial state of the client, how well they accept the diagnosis, and the sex of the patient

(3) Most cancer publications state the pain aspect as falling into the type of cancer, the stage of cancer, and the pain tolerance of the individual.

**150.** The major side effects of narcotics are:

1. hunger, thirst, drowsiness, and tinnitus.
2. drowsiness, constipation, dry mouth, nausea, and vomiting.
3. dry mouth, heart palpitations, and tachycardia.
4. hunger, drowsiness, hallucinations, and diarrhea.

(2) The major side effects of narcotics are: drowsiness, constipation, dry mouth, nausea and vomiting. Others might include dizziness, mental effects (confusion, hallucinations), decrease in rate and depth of breathing or difficulty in urinating.

**151.** The functions of the skin are:

1. protection, sensation, temperature regulation and excretion/secretion.
2. protection, temperature regulation, acid Ph of the skin is low due to its ability to prevent toxicity.
3. acid Ph high to prevent toxicity, sensation, second line of defense.
4. acid Ph high to prevent microorganisms secretion/excretion of all waste materials.

(1) The functions of the skin are protection (barrier to microorganisms), sensation (pain, temperature, pressure-nerve receptors temperature regulation [cold/heat regulation], excretion/secretion (chemicals produced toxic to bacteria; skin secretions inhibit bacterial growth).

**152.** A newborn requires only sponge baths, not tub baths to:

1. prevent chilling and heat loss.
2. prevent overdrying of skin.
3. prevent vasodilation.
4. prevent loss of chemicals.

(1) The newborn should be dried immediately and wrapped to prevent heat loss, especially since shivering starts at a lower body temperature and there is greater body surface area for heat loss compared to adults.

**153.** In the older adult, excessive skin care may:

1. contribute to vasoconstriction.
2. contribute to dry skin.
3. contribute to excessive loss of body nutrients.
4. contribute to vasodilation.

(2) Excessive skin care as bathing may contribute to dry skin in the older adult due to nutrition and the condition of the body.

**154.** Hygiene practices may vary among:

1. cultures.
2. religions.
3. race.
4. ethnicity.

(1) Hygiene practices vary considerably among different cultures; in some cultures, daily bathing is a ritual, whereas in other cultures, a weekly routine is acceptable; some cultures worry about hot/cold imbalances as a cause of illness; some cultures avoid bathing during menstruation and child birth.

**155.** Major skin problems that should alert the nurse to assess and give appropriate care are:

1. pruritus, abrasions, excoriations, dermatitis.
2. pruritus, excoriations, wetness.
3. ulcers, erythema, excoriations, hairiness.
4. vein appearance, pruritus, bony prominences.

(1) Pruritus (itching) can accompany many skin lesions or skin problems and should be investigated; abrasions may appear as a result of trauma to the skin; excoriations are areas of skin that have been formed due to many conditions (both external and internal); dermatitis may be a sign of infection.

**156.** In a specific hygiene measure as a partial bed bath, the nurse should:

1. wash the patient in private thoroughly every day.
2. explain the procedure to the patient and provide privacy and safety.
3. provide safety, assemble all equipment, and have the family do the bath.
4. explain the procedure to the patient, explain that the patient must take a bath daily, and provide safety.

(2) Explaining the procedure to the patient, providing privacy and safety will allow the patient to offer participation, have knowledge of procedure and reduce anxiety.

**157.** Pressure ulcers (decubitus ulcers) usually occur:

1. when patients are left in one position in bed for extended periods of time.
2. when the patient is “thin” (weight).
3. when the patient is “heavy” (weight).
4. always in both “thin” and “heavy” patients.

(1) Pressure ulcers (decubitus ulcers) usually occur over bony prominences caused by decreased circulation. The patient that is left in one position in bed for extended periods of time is more prone to decreased circulation to an area of the body; thereby, possibly acquiring a pressure ulcer.

**158.** Correct and accurate documentation of assessment findings regarding pressure ulcers is very important because:

1. the law requires the nurse to document lesions.
2. the hospital requires the nurse to document lesions.
3. the doctor requires the nurse to document lesions.
4. the nursing assessment of lesions falls into a standard of nursing practice.

(4) Documentation of assessments by the nurse enables earlier interventions to help prevent further progression of the lesion.

**159.** Perineal care to a female patient by the nurse can be done:

1. without gloves, pouring water from a sterile bottle.
2. without gloves, having the patient do all care.
3. with gloves, washing the perineal area from front to back.
4. with gloves, washing the perineal area from back to front.

(3) With gloves always, washing the perineal area with a washcloth from front to back. This method allows for the additional e-coli and other bacteria from being swept into the vaginal area. The procedure should be in a private area with procedure explanation and all equipment gathered first.

**160.** Documentation of the perineal care should include:

1. the time and place of the procedure only.
2. the procedure and assessment of stools/urine.
3. the willingness of the client to participate.
4. the procedure, time, and assessment of the client (particularly perineal region).

(4) The documentation is extremely important so that continual care may be given and the nurse can follow any documented problems or areas of concern.

**161.** Nail and foot care are essential in meeting basic hygiene needs of the client. Important assessments by the nurse in this area include:

1. all body assessment, including the feet and nails.
2. the essential lab work of the client.
3. the nail beds and the tissue surrounding the nails.
4. foot corns and calluses only.

(3) The nail beds and the tissue surrounding the nails should be assessed for abnormal discoloration, lesions, paronychia (infection of tissue surrounding the nail), tissue dryness, breaks in skin, pressure areas, or other abnormal appearances.

**162.** For a client requiring total oral care, it is important for the nurse to:

1. assemble all equipment, assist client to a semi-Fowler's position, and place towel on chest.
2. place client in a fowler's position, prepare equipment, and tell client what to do.
3. assemble all equipment, place client in side-lying position, and place a towel under chin.
4. use gloves and clean client's mouth, including tongue.

(3) Assemble equipment first, place client in a side-lying position so fluid can easily flow out or pool inside of mouth for suctioning (prevent aspiration), place towel under client's chin and a curved basin against chin, and use gloves.

**163.** The client's room environment includes:

1. preparation and making of client's bed, fresh water, thermostat regulation, cleaning floors and all occupied client's areas.
2. preparation and making of client's bed, ensure comfort and safety, keep area clutter-free, put client's hygiene articles near.
3. prevent accidents, provide comfort, wash all areas of room (including furniture) with chloroseptic wash, make client's bed every other day.
4. control all odors by spraying room with deodorizers; keep all objects of client's in closet, wear gloves to clean room.

(2) Preparation and making of client's bed, ensuring comfort and safety at all times with client; keeping the area clutter-free, keeping client's hygiene articles near, explaining all procedures first; and having client assist with personal arrangement of articles are all part of the client's room environment

**164.** A client is hospitalized for the first time. Which of the following actions ensures safety of the client?

1. Keep unnecessary furniture out of the way.
2. Keep lights on all the time.
3. Keep side rails up at all times.
4. Keep all equipment out of view.

(1) The environment has to be clutter-free; therefore, unnecessary pieces of equipment or furniture have to be put out of the way. Lights on and side rails up are not mandatory at all times. It is unnecessary to keep equipment out of view.

**165.** A client who is unconscious needs frequent mouth care; in what position should the client be placed?

1. Fowler's position
2. side-lying position
3. supine position
4. Trendelenburg position

(2) In side-lying position, fluid is more likely to flow readily out of the mouth or pool in the side of the mouth where it can easily be suctioned. Fowler's position and Trendelenburg position are not appropriate since the unconscious client does not have control to stay up in those positions. The supine is unsafe as the client may aspirate the fluids.

**166.** What are the factors that might make the nurse's client reluctant to participate in morning care?

1. illness, injury, cultural, stress
2. illness, behavior, dependency
3. disease, infection, doesn't want to, high energy level
4. nursing care poor

(1) Illness, injury, culture, and stress can interfere with a client's reluctance to participate in morning care. Hopefully option 4 is not true as well as 2 and 3.

**167.** Why should the nurse have the client participate in their morning hygiene care?

1. promotes cleanliness and decreases illness
2. promotes health and well-being
3. promotes happiness and greater recovery
4. promotes skills and new procedures

(2) Enhances the client's health status and emotional well-being. Promotes a sense of positive self-image, better self-concept, and independence with a sense of control.

**168.** Potentials for altered self-care are:

1. increased energy.
2. comfort/sense of well-being.
3. cognitive dysfunction.
4. environmental dysfunction.

(3) Cognitive dysfunction can alter self-care functioning; also decrease energy; acute pain, and illness surgery; neuro-muscular impairment; sensorimotor defects; environmental limitation; emotional disturbance, and depression.

**169.** Which action is completed when removing contaminated clothing and bed linen from a client?

1. Scrub hands and arms well.
2. Carry contaminated clothing/bed linen away from nurse's body.
3. Doesn't matter how contaminated, items are disposed of.
4. Wash hands.

(2) Infection control and safety factors are carried out to prevent this client from acquiring any outside bacteria as well as other clients acquiring this patient's bacteria.

**170.** Which step should be avoided when bathing a client who has a history of deep vein thrombosis?

1. sliding the basin under the foot while supporting and raising the lower leg
2. using long, firm strokes when washing from the ankles to knees
3. patting the skin gently with a towel to dry it after bathing
4. cleaning between the toes when bathing the feet

(2) When bathing this client with deep vein thrombosis, it is important to not use long, firm strokes when washing from ankles to knees, so as to help prevent a possible embolism.

**171.** Which is the best way for the nurse to position a hemiplegic client in a semi-Fowler's position?

1. Turn the client to one side and support with a back pillow.
2. Position client's head on a large, firm pillow.
3. Elevate head and trunk 70–90 degrees.
4. Flex the client's knees.

(4) The best way for a nurse to position a hemiplegic client in a semi-Fowler's position is to flex the client's knees (mobility and exercise).

**172.** Select an appropriate technique for shaving a male client.

1. Soften the beard with a warm, moist towel before beginning.
2. Use downward strokes when shaving the neck.
3. Use a safety razor when shaving a client who is at risk for excessive bleeding.
4. Use upward strokes when shaving the face.

(1) Soften the beard with a warm, moist towel before beginning this will help with softening on skin; then apply shaving cream. Strokes should be in the direction of the hair growth on face and neck; a safety razor should be used on all clients.

**173.** Select the best effective nursing action to meet the self-esteem needs of a client.

1. Refer the client to a psychologist.
2. Encourage the family to meet more of the client's needs.
3. Help the client set small achievable goals.
4. Repeat explanations of treatments and procedures.

(3) The nurse should create a therapeutic environment; encourage positive reinforcement; assist in small achievable goals, and reinforce progress in a positive supporting manner.

**174.** Which documented statement reflects the most important nursing action to prevent skin breakdown?

1. "All bony prominences massaged."
2. "No reddened areas noted during bath."
3. "Heels supported on a foam donut."
4. "Repositioning side-back-side q2h."

(4) Repositioning q2h will help the client to have pressured body parts relieved and increase circulation, thereby reducing skin breakdown.

**175.** What are two important considerations to be incorporated into the bed/bath procedure?

1. Ensure client privacy and maintain warmth.
2. Maintain professionalism and do all care for the client.
3. Allow client independence and assist only with skin care.
4. Maintain client dignity and ask the family to provide perineal care.

(1) Always ensure privacy and maintain environment free from drafts and temperature suitable to client; have client participate with as much as possible to promote independence.

**176.** Ms. Petty is having difficulty falling asleep. Which of the following measures would promote sleep in this client?

1. Permit her to exercise vigorously 20 minutes nightly at 9:30.
2. Encourage her to take a cool shower and a hot cup of tea.
3. Recommend watching TV nightly until midnight.
4. Provide a back rub and a glass of warm milk.

(4) These are appropriate measure to promote sleep. Options 1, 2, and 3 are all stimulation actions that would increase arousal.



**177.** A 4-year-old client is unable to go to sleep at night in the hospital. Which nursing interventions may best help promote sleep for the child?

1. Turn out the room light and close the door.
2. Tire the child during the evening with play exercises.
3. Identify the child's home bedtime rituals and follow them.
4. Encourage visitation by friends during the evening.

(3) Preschool-aged children require bedtime rituals that should be followed in the hospital if possible. Option 1 would increase a child's fear. Options 2 and 4 would not promote sleep.

**178.** The 24-hour day-night cycle is known as:

1. circadian rhythm.
2. infradian rhythm.
3. ultradian rhythm.
4. non-REM rhythm.

(1) Circadian rhythm is rhythmic repetition of patterns during each 24 hours; sleep is a complex biologic rhythm; if a person's biologic clock coincides with the sleep-wake patterns, the person is in circadian synchronization.

**179.** The nurse in teaching a client about sleep, gives background information on normal sleep patterns. The nurse states that which of the following substance(s) will promote sleep patterns?

1. serotonin
2. cortisone
3. alcohol
4. narcotics

(1) Serotonin is a substance that is in the body and promotes sleep: Serotonin may play a role in synthesis of a hypnogenic factor that directly causes sleep. Drugs and substances disrupt REM sleep, although it may accelerate onset of sleep.

**180.** A hospitalized adult client who routinely works from midnight until 8 AM has a temperature of 99.1°F at 4 AM. The nurse determines that this is most likely due to:

1. delta sleep.
2. slow brain waves.
3. pneumonia.
4. circadian rhythm.

(4) Biological rhythms that follow a cycle about 24 hours are termed circadian rhythm. The sleep-wake cycle is closely linked with the cardiac rhythms, such as body temperature. While a person sleeps, core body temperature drops, often reaching the 24-hour low around 4 AM. When the sleep period shifts, temperature fluctuations also shift to match the new sleep patterns.

**181.** Mrs. Peterson complains of difficulty falling asleep, awakening earlier than desired, and not feeling rested. She attributes these problems to leg pain that is secondary to her arthritis. What would be the appropriate nursing diagnosis for her?

1. sleep pattern disturbances related to arthritis
2. fatigue related to leg pain
3. knowledge deficit regarding sleep hygiene measures
4. sleep pattern disturbances related to chronic leg pain

(4) Sleep patterns directly are majorly disturbed by the chronic leg pain, which is secondary to the arthritis. This nursing diagnosis is the appropriate one for the nurse to directly deal with, that is, comfort measures, and so on.

**182.** The nurse provides the postoperative client with an analgesic medication and darkens the room before the client goes to sleep for the night. The nurse's actions:

1. help the client's circadian rhythm.
2. stimulate hormonal changes in the brain.
3. decrease stimuli from the cerebral cortex.
4. alert the hypothalamus in the brain.

(3) Reduction of environmental stimuli, particularly light and noise, facilitate sleep, particularly from the cerebral cortex, which can be an area of arousal. Sleep occurs when there is a decreased input into this area.

**183.** Following an automobile accident that caused a head injury to an adult client, the nurse observes that the client sleeps for long periods of time. The nurse determines that the client has experienced injury to the:

1. hypothalamus.
2. thalamus.
3. cortex.
4. medulla.

(1) The hypothalamus, when injured, can cause fluctuations and disruptions to the sleep patterns.

**184.** A nursing care plan for a client with sleep problems has been implemented. All of the following would be expected outcomes except:

1. client reports no episodes of awakening during the night.
2. client falls asleep within 1 hour of going to bed.
3. client reports satisfaction with amount of sleep.
4. client rates sleep as an 8 or above on the visual analog scale.

(2) The stages of sleep are defined by four stages. Stage 3 or 4 (within a short period of time—usually one hour) is considered the deep part of sleep.

**185.** All of the following are symptoms of sleep deprivation except:

1. hyperactivity.
2. irritability.
3. rise of body temperature.
4. decreased motivation.

(3) The sleep-wake cycle is closely linked with the cardiac rhythms, such as body temperature. While a person sleep, core body temperature drops, often reaching the 24-hour low. When the sleep period shifts, temperature fluctuations also shift to match the new sleeping patterns.

**186.** The nurse empties a foley catheter bag for a client who appears to be asleep. The client is easily aroused when the nurse is close to the client's bedside. The nurse determines that the client was most likely in the non-REM sleep stage:

1. I.
2. II.
3. III.
4. IV.

(2) Stage II is still a relatively light sleep from which the person is easily awakened.

**187.** An adult client visits the sleep disorder clinic for assessment. The nurse should instruct the client that routine studies for sleep disorders include an EEG and:

1. EOG.
2. KUB.
3. RUI.
4. CAT.

(1) EOG, Electroculogram, eye movements is a polygraph recording. The other answers are not related to sleep.

**188.** A client who has just delivered a healthy newborn asks the nurse about newborn sleep patterns. The nurse should instruct the client that for the first three weeks newborns generally:

1. have less REM sleep than older children.
2. demonstrate alert inactivity with eyes open.
3. sleep 14–20 hours per day.
4. need two naps per day.

(3) Newborns sleep 14–20 hours per day in the first 6 weeks. This is “normal” for newborns.

**189.** When discussing newborn sleep patterns with a first-time mother, the client asks, “When will my baby sleep through the night?” The best response by the nurse is to instruct the client that newborns generally sleep through the night by:

1. 1 month of age.
2. 2–4 months of age.
3. 5–6 months of age.
4. 7–8 months of age.

(2) The number of sleep periods continues to drop from 4–5 per 24 hours at 3 months of age to 1 nighttime period and 2 naps at 6 months.

**190.** A client tells the nurse that she has been suffering from chronic fatigue even though she has been getting 10–12 hours of sleep per day. The nurse should assess the:

1. dietary deficiencies.
2. lifestyle stressors.
3. symptoms of illness.
4. parasomnia.

(3) Numerous situational variables are superimposed on developmental considerations, need, and individual variables affecting sleep and rest patterns. One of these is illness, which can have a large impact on sleep.

**191.** A hospitalized adult client is asleep when the nurse assesses the client’s blood pressure. The nurse observes that the client’s respirations are irregular, and there is a 5-second period of apnea between respirations. The nurse determines that the client is experiencing:

1. non-REM sleep.
2. REM sleep.
3. narcolepsy.
4. sleep apnea.

(2) REM sleep resembles wakefulness except for very low muscle tone. Respirations are irregular and oxygen consumption increases.

**192.** The nurse is caring for a 3-year-old child hospitalized following an automobile injury. The nurse observes that the toddler awakens several times during the night. The nurse should:

1. administer an ordered pain medication.
2. ask the child why he keeps awakening.
3. ask the child's mother to stay with him.
4. provide comfort measures to the child.

(4) Some sleep disturbances are observed in almost all children and thought to be related to the rapidly developing mental abilities of the child. Frequent awakening and occasional night terrors may also occur.

**193.** While discussing sleep patterns of school-age children with a group of parents, which of the following would be appropriate for the nurse to include in the teaching plan? School-age children:

1. often have difficulty sleeping through the night.
2. may require less sleep during growth spurts.
3. generally sleep 8 to 10 hours each night.
4. enjoy staying up late and sleeping late in the morning.

(3) School-age children have sleep and rest fluctuations in relation to growth spurts and activity patterns.

**194.** The nurse is planning a presentation for a group of adults age 65 or older about sleep. Which of the following should be included in the teaching plan?

1. Sleep-wakefulness patterns are often altered as one ages.
2. The amount of REM sleep increases as one ages.
3. Some adults have no Stage I sleep after the age of 60.
4. Over the age of 60, clients are less likely to be disturbed by noise.

(1) As people age, the amount of Stage IV sleep decreases significantly. Circadian rhythms become less prominent with increasing age.

**195.** A client tells the nurse that he has been experiencing insomnia the past few days. The nurse should suggest to the client that an appropriate snack before bedtime to aid the sleep process is:

1. orange juice.
2. crackers.
3. hot chocolate.
4. bananas.

(2) Diet can have a large impact on sleep patterns. Depending upon the adequacy of the diet, the intake of diet will have an affect on the sleep patterns.

**196.** While caring for an adult male client, the nurse observes that the client is snoring while sleeping and stops breathing for 20 seconds between the snoring. The nurse determines that the client is more likely experiencing:

1. narcolepsy.
2. hypersomnia.
3. parasomnia.
4. sleep apnea.

(4) Sleep apnea syndrome can be classified as obstructive or central. The syndrome is associate with bad snores or gasps followed by a period of apnea that lasts 20–30 seconds.

**197.** A hospitalized client tells the nurse that he has been unable to sleep. To obtain more data related to the client's sleep problem, the nurse should first ask:

1. "How many hours of sleep do you need?"
2. "Do you take naps during the day?"
3. "Can you tell me about your sleep problem?"
4. "Do you need medication to help you sleep?"

(3) Sleep patterns vary in adults. Environment, diet, stress, activity, and illness can cause these variations. Sleep is not a period of mere physiological quiescence, but a complex phenomenon, which results from differences in people. First, the nurse needs to assess the individual's usual habits.

**198.** A 39-year-old client is seen in the clinic because she has been sleeping 14–16 hours a day. The client states that she is "depressed because my mother died from cancer two months ago." A priority nursing diagnosis for this client is:

1. altered sleep patterns related to depression and grief response.
2. depression related to loss of mother and excessive sleeping.
3. sleep pattern disturbance related to inability to resolve grief.
4. sleep pattern disturbance related to grief process and loss of mother.

(4) Environment, diet, stress, activity, and illness can cause variations in sleep patterns. When an individual experiences psychological stress, the amount of deep sleep and total sleep time can change sleep patterns.

**199.** The nurse is caring for a client who had a restless night due to postoperative pain. When the nurse enters the room at 7 AM for morning vital signs, the client is sound asleep. The nurse should:

1. document that the client was asleep at 7 AM and leave the room.
2. assess the client's vital signs while trying not to disturb him.
3. ask the night shift nurse what the client's vital signs were at 4 AM.
4. allow the client to rest and assess the vital signs later in the morning.

(4) Postoperative clients have had physiological stress to their body systems; therefore, they are in need of both rest and sleep. Unless there is a stronger need for a procedure, it is better to allow this client to sleep.

**200.** A 79-year-old client tells the nurse that she has been taking Prozac for several months but still feels tired after 8 hours of sleep. The nurse should assess the client for:

1. hallucinations.
2. depression.
3. nightmares.
4. twitching.

(2) The client on antidepressant medication may need further treatment if depression still persists.



# Pharmacological Therapies

This chapter contains questions and answers from the following topic areas:

- Adverse Effects/Contraindications and Side Effects
- Blood and Blood Products
- Central Venous Access Devices
- Dosage Calculations
- Expected Effects
- Intravenous Therapy
- Medication Administration
- Pharmacological Agents/Actions
- Pharmacological Pain Management
- Total Parenteral Nutrition

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

1. lungs
2. liver
3. kidneys
4. adrenal glands

(2) Acetaminophen is extensively metabolized by pathways in the liver. Toxic doses of acetaminophen deplete hepatic glutathione, resulting in accumulation of the intermediate agent, quinone, which leads to hepatic necrosis. Prolonged use of acetaminophen may result in an increased risk of renal dysfunction, but a single overdose does not precipitate life-threatening problems in the respiratory system, renal system, or adrenal glands.

**2.** A contraindication for topical corticosteroid usage in a patient with atopic dermatitis (eczema) is:

1. parasite infection.
2. viral infection.
3. bacterial infection.
4. spirochete infection.

(2) Topical agents produce a localized, rather than systemic effect. When treating atopic dermatitis with a steroidal preparation, the site is vulnerable to invasion by organisms. Viruses, such as herpes simplex or varicella-zoster, present a risk of disseminated infection. Educate the patient using topical corticosteroids to avoid crowds or people known to have infections and to report even minor signs of an infection. Topical corticosteroid usage results in little danger of concurrent infection with these agents.

**3.** In infants and children, the side effects of first generation over-the-counter (OTC) antihistamines, such as diphenhydramine (Benadryl) and hydroxyzine (Atarax) include:

1. Reye's syndrome.
2. cholinergic effects.
3. paradoxical CNS stimulation.
4. nausea and diarrhea.

(3) Typically, first generation OTC antihistamines have a sedating effect because of passage into the CNS. However, in some individuals, especially infants and children, paradoxical CNS stimulation occurs and is manifested by excitement, euphoria, restlessness, and confusion. For this reason, use of first generation OTC antihistamines has declined, and second generation product usage has increased. Reye's syndrome is a systemic response to a virus. First generation OTC antihistamines do not exhibit a cholinergic effect. Nausea and diarrhea are uncommon when first generation OTC antihistamines are taken.

**4.** Reye's syndrome, a potentially fatal illness associated with liver failure and encephalopathy is associated with the administration of which over-the-counter (OTC) medication?

1. acetaminophen (Tylenol)
2. ibuprofen (Motrin)
3. aspirin
4. brompheniramine/pseudoephedrine (Dimetapp)

(3) Virus-infected children who are given aspirin to manage pain, fever, and inflammation are at an increased risk of developing Reye's syndrome. Use of acetaminophen has not been associated with Reye's syndrome and can be safely given to patients with fever due to viral illnesses. Ibuprofen adverse effects include GI irritation and bleeding, and in toxic doses, both renal and hepatic failure are reported. However, ibuprofen has not been associated with the onset of Reye's disease. Brompheniramine/pseudoephedrine contains a first generation OTC antihistamine and a decongestant. Neither agent has been associated with the development of Reye's syndrome.

**5.** Patients who are allergic to intravenous contrast media are usually also allergic to which of the following products?

1. eggs
2. shellfish
3. soy
4. acidic fruits

(2) Some types of contrast media contain iodine as an ingredient. Shellfish also contain significant amounts of iodine. Therefore, a patient who is allergic to iodine will exhibit an allergic response to both iodine containing contrast media and shellfish. These products do not contain iodine.

**6.** A 14-month-old child recently arrived in the United States from a foreign country with his parents and needs childhood immunizations. His mother reports that he is allergic to eggs. Upon further questioning, you determine that the allergy to eggs is anaphylaxis. Which of the following vaccines should he not receive?

1. hepatitis B
2. inactivated polio
3. diphtheria, acellular pertussis, tetanus (DTaP)
4. mumps, measles, rubella (MMR)

(4) The measles portion of the MMR vaccine is grown in chick embryo cells. The current MMR vaccine does not contain a significant amount of egg proteins, and even children with dramatic egg allergies are extremely unlikely to have an anaphylactic reaction. However, patients that do respond to egg contact with anaphylaxis should be in a medically controlled setting where full resuscitation efforts can be administered if anaphylaxis results. The vaccines in options 1–3 do not contain egg protein.



**7.** The Gell and Coombs classification system categorizes allergic reactions and is useful in describing and classifying patient reactions to drugs. Type I reactions are immediate hypersensitivity reactions and are mediated by:

1. immunoglobulin E (IgE).
2. immunoglobulin G (IgG).
3. immunoglobulin A (IgA).
4. immunoglobulin M (IgM).

(1) IgE, the least common serum immunoglobulin (Ig) binds very tightly to receptors on basophils and mast cells and is involved in allergic reactions. Binding of the allergen to the IgE on the cells results in the release of various pharmacological mediators that result in allergic symptoms. IgG is the major Ig (75 percent of serum Ig is IgG). Most versatile Ig because it is capable of carrying out all of the functions of Ig molecules. IgG is the only class of Ig that crosses the placenta. It is an opsonin, a substance that enhances phagocytosis. IgA, the second most common serum Ig is found in secretions (tears, saliva, colostrum, and mucus). It is important in local (mucosal) immunity. IgM, the third most common serum Ig, is the first Ig to be made by the fetus and the first Ig to be made by a virgin B cell when it is stimulated by antigen. IgM antibodies are very efficient in leading to the lysis of microorganisms.

**8.** Drugs can cause adverse events in a patient. Bone marrow toxicity is one of the most frequent types of drug-induced toxicity. The most serious form of bone marrow toxicity is:

1. aplastic anemia.
2. thrombocytosis.
3. leukocytosis.
4. granulocytosis.

(1) Aplastic anemia is the result of a hypersensitivity reaction and is often irreversible. It leads to pancytopenia, a severe decrease in all cell types: red blood cells, white blood cells, and platelets. A reduced number of red blood cells causes hemoglobin to drop. A reduced number of white blood cells makes the patient susceptible to infection. And, a reduced number of platelets causes the blood not to clot as easily. Treatment for mild cases is supportive. Transfusions may be necessary. Severe cases require a bone marrow transplant. Option 2 is an elevated platelet count. Option 3 is an elevated white count. Option 4 is an elevated granulocyte count. A granulocyte is a type of white blood cell.

**9.** Serious adverse effects of oral contraceptives include:

1. increase in skin oil followed by acne.
2. headache and dizziness.
3. early or mid-cycle bleeding.
4. thromboembolic complications.

(4) Oral contraceptives have been associated with an increased risk of stroke, myocardial infarction, and deep vein thrombosis. These risks are increased in women who smoke. Increased skin oil and acne are effects of progestin excess. Headache and dizziness are effects of estrogen excess. Early or mid-cycle bleeding are effects of estrogen deficiency.

**10.** The most serious adverse effect of Alprostadil (Prostin VR pediatric injection) administration in neonates is:

1. apnea.
2. bleeding tendencies.
3. hypotension.
4. pyrexia.

(1) All items are adverse reactions of the drug. However, apnea appearing during the first hour of drug infusion occurs in 10–12 percent of neonates with congenital heart defects. Clinicians deciding to utilize alprostadil must be prepared to intubate and mechanically ventilate the infant. Careful monitoring for apnea or respiratory depression is mandatory. In some institutions, elective intubation occurs prior to initiation of the medication.

**11.** Your patient calls the clinic today because he is taking atorvastatin (Lipitor) to treat his high cholesterol and is having pain in both of his legs. You instruct him to:

1. stop taking the drug and make an appointment to be seen next week.
2. continue taking the drug and make an appointment to be seen next week.
3. stop taking the drug and come to the clinic to be seen today.
4. walk for at least 30 minutes and call if symptoms continue.

(3) Muscle aches, soreness, and weakness may be early signs of myopathy such as rhabdomyolysis associated with the HMG-CoA reductase class of antilipemic agents. This patient will need an immediate evaluation to rule out myopathy. Additional doses may exacerbate the problem. Exercise will not reverse myopathy and delays diagnosis.

**12.** Which of the following adverse effects is associated with levothyroxine (Synthroid) therapy?

1. tachycardia
2. bradycardia
3. hypotension
4. constipation

(1) Levothyroxine, especially in higher doses, can induce hyperthyroid-like symptoms including tachycardia. An agent that increases the basal metabolic rate would not be expected to induce a slow heart rate. Hypotension would be a side effect of bradycardia. Constipation is a symptom of hypothyroid disease.

**13.** Which of the following adverse effects is specific to the biguanide diabetic drug metformin (Glucophage) therapy?

1. hypoglycemia
2. GI distress
3. lactic acidosis
4. somnolence

(3) Lactic acidosis is the most dangerous adverse effect of metformin administration with death resulting in approximately 50 percent of individuals who develop lactic acidosis while on this drug. Metformin does not induce insulin production; thus, administration does not result in hypoglycemic events. Some nausea, vomiting, and diarrhea may develop but is usually not severe. NVD is not specific for metformin. Metformin does not induce sleepiness.

**14.** The most serious adverse effect of tricyclic antidepressant (TCA) overdose is:

1. seizures.
2. hyperpyrexia.
3. metabolic acidosis.
4. cardiac arrhythmias.

(4) Excessive ingestion of TCAs result in life-threatening wide QRS complex tachycardia. TCA overdose can induce seizures, but they are typically not life-threatening. TCAs do not cause an elevation in body temperature. TCAs do not cause metabolic acidosis.

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

1. 0.9 percent sodium chloride
2. 5 percent dextrose in water solution
3. sterile water
4. heparin sodium

(1) 0.9 percent sodium chloride is normal saline. This solution has the same osmolarity as blood. Its use prevents red cell lysis. The solutions given in options 2 and 3 are hypotonic solutions and can cause red cell lysis. The solution in option 4 may anticoagulate the patient and result in bleeding.

**16.** A patient asks the nurse whether all donor blood products are cross-matched with the recipient to prevent a transfusion reaction. Which of the following always require cross-matching?

1. packed red blood cells
2. platelets
3. plasma
4. granulocytes

(1) Red blood cells contain antigens and antibodies that must be matched between donor and recipient. The blood products in options 2–4 do not contain red cells. Thus, they require no cross-match.

**17.** A month after receiving a blood transfusion an immunocompromised patient develops fever, liver abnormalities, a rash, and diarrhea. The nurse would suspect this patient has:

1. nothing related to the blood transfusion.
2. graft-versus-host disease (GVHD).
3. myelosuppression.
4. an allergic response to a recent medication.

(2) GVHD occurs when white blood cells in donor blood attack the tissues of an immunocompromised recipient. This process can occur within a month of the transfusion. Options 1 and 4 may be a thought, but the nurse must remember that immunocompromised transfusion recipients are at risk for GVHD.

**18.** A client comes into the local blood donation center. He says he is here to donate platelets only today. The nurse knows this process is called:

1. directed donation.
2. autologous donation.
3. allogenic donation.
4. apheresis.

(4) The process of apheresis involves removal of whole blood from a donor. Within an instrument that is essentially designed as a centrifuge, the components of whole blood are separated. One of the separated portions is then withdrawn, and the remaining components are retransfused into the donor. Directed donation is collected from a blood donor other than the recipient, but the donor is known to the recipient and is usually a family member or friend. Autologous donation is the collection and reinfusion of the patient's own blood. Allogenic donation is collected from a blood donor other than the recipient.

**19.** The nurse knows that the age group that uses the most units of blood and blood products is:

1. premature infants.
2. children ages 1–20 years.
3. adults ages 21–64 years.
4. the elderly above age 65 years.

(4) People older than 65 years use 43 percent of donated blood. This number is expected to increase as the population ages.

**20.** A child is admitted with a serious infection. After two days of antibiotics, he is severely neutropenic. The physician orders granulocyte transfusions for the next four days. The mother asks the nurse why? The nurse responds:

1. "This is the only treatment left to offer the child."
2. "This therapy is fast and reliable in treating infections in children."
3. "The physician will have to explain his rationale to you."
4. "Granulocyte transfusions replenish the low white blood cells until the body can produce its own."

(4) Granulocyte (neutrophil) replacement therapy is given until the patient's blood values are normal and he is able to fight the infection himself. Options 1 and 3 are not therapeutic responses. The treatment in option 2 takes days and is not always able to prevent morbidity and mortality.

**21.** A neighbor tells a nurse he has to have surgery and is reluctant to have any blood product transfusions because of a fear of contracting an infection. He asks the nurse what are his options. The nurse teaches the person that the safest blood product is:

1. an allogenic product.
2. a directed donation product.
3. an autologous product.
4. a cross-matched product.

(3) This process is the collection and reinfusion of the patient's own blood. It is recommended by the American Medical Association's Council on Scientific Affairs as the safest product since it eliminates recipient incompatibility and infection. The product in option 1 is collected from a blood donor other than the recipient. The process in option 2 is also collected from a blood donor other than the recipient, but the donor is known to the recipient and is usually a family member or friend. Cross-matching significantly enhances compatibility. It does not detect infection.

**22.** A severely immunocompromised patient requires a blood transfusion. To prevent GVHD, the physician will order:

1. diphenhydramine hydrochloride (Benadryl).
2. the transfusion to be administered slowly over several hours.
3. irradiation of the donor blood.
4. acetaminophen (Tylenol).

(3) This process eliminates white blood cell functioning, thus, preventing GVHD. Diphenhydramine HCl is an antihistamine. Its use prior to a blood transfusion decreases the likelihood of a transfusion reaction. Option 2 will not prevent GVHD. Use of acetaminophen prevents and treats the common side effects of blood administration caused by the presence of white blood cells in the transfusion product: fever, headache, and chills.

**23.** A patient who is to receive a blood transfusion asks the nurse what is the most common type of infection he could receive from the transfusion. The nurse teaches him that approximately 1 in 250,000 patients contract:

1. human immunodeficiency disease (HIV).
2. hepatitis C infection.
3. hepatitis B infection.
4. West Nile viral disease.

(3) Hepatitis B is the most common infection spread via blood transfusion. Donors are screened by a questionnaire that includes symptoms. The donated blood is also tested for infection. The risk of infection with the agents in options 2 and 3 has decreased to approximately 1 in 2 million secondary to donor questioning and donor blood testing. The incidence of West Nile viral transmission is unknown, but donor infection is still relatively rare.

**24.** A patient with blood type AB, Rh factor positive needs a blood transfusion. The Transfusion Service (blood bank) sends type O, Rh factor negative blood to the unit for the nurse to infuse into this patient. The nurse knows that:

1. this donor blood is incompatible with the patient's blood.
2. premedicating the patient with diphenhydramine hydrochloride (Benadryl) and acetaminophen (Tylenol) will prevent any transfusion reactions or side effects.
3. this is a compatible match.
4. the patient is at minimal risk receiving this product since it is the first time he has been transfused with type O, Rh negative blood.

(3) Type O, Rh negative blood has none of the major antigens and is safely administered to patients of all blood types. It is also known as the universal donor. Premedicating with these agents will not prevent a major transfusion reaction if the blood type and Rh factors of the donor blood are incompatible with the recipient's blood.

**25.** The physician orders 250 milliliters of packed red blood cells (RBC) for a patient. This therapy is administered for treatment of:

1. thrombocytopenia.
2. anemia.
3. leukopenia.
4. hypoalbuminemia.

(2) A red blood cell transfusion is used to correct anemia in patients in which the low red blood cell count must be rapidly corrected. RBC transfusion will not correct a low platelet count. RBC transfusion will not correct a low white blood cell count. Packed RBCs contain very little plasma and, thus, only a small amount of albumin. This amount will not correct low albumin levels.

**26.** A patient needs a whole blood transfusion. In order for transfusion services (the blood bank) to prepare the correct product a sample of the patient's blood must be obtained for:

1. a complete blood count and differential.
2. a blood type and cross-match.
3. a blood culture and sensitivity.
4. a blood type and antibody screen.

(2) This is needed to utilize the correct type of donor blood and to match the donor product with the patient. Incompatible matches would result in severe adverse events and possible death. The tests in options 1 and 3 are unnecessary. The test in option 4 is utilized to determine the patient's blood type and presence of antibodies to blood antigens. It does not determine donor blood compatibility with the patient.

**27.** A patient needs to receive a unit of whole blood. What type of intravenous (IV) device should the nurse consider starting?

1. a small catheter to decrease patient discomfort
2. the type of IV device the patient has had in the past, which worked well
3. a large bore catheter
4. the type of device the physician prefers

(3) Large bore catheters prevent damage to blood components and are less likely to develop clotting problems than a small bore catheter. The nurse should determine the correct device without asking the patient what type has been used before or asking the physician which type he prefers and start the IV.

**28.** The physician orders a gram of human salt poor albumin product for a patient. The product is available in a 50 milliliter vial with a concentration of 25 percent. What dosage will the nurse administer?

1. The nurse should use the entire 50 milliliter vial.
2. The nurse should determine the volume to administer from the physician.
3. This concentration of product should not be used.
4. The nurse will administer 4 milliliters.

(4) A 25 percent solution contains one quarter of a gram per milliliter. Thus, the nurse will administer 4 milliliters to provide a complete gram of albumin. The volume in option 1 would provide 12.5 grams of albumin. The nurse should determine the volume. It is unnecessary to seek the answer from the physician. A 25 percent solution is an acceptable product and can safely be used.

**29.** Central venous access devices (CVADs) are frequently utilized to administer chemotherapy. What is a distinct advantage of using the CVAD for chemotherapeutic agent administration?

1. CVADs are less expensive than a peripheral IV.
2. Once a week administration is possible.
3. Caustic agents in small veins can be avoided.
4. The patient or his family can administer the drug at home.

(3) Many chemotherapeutic drugs are vesicants (highly active corrosive materials that can produce tissue damage even in low concentrations). Extravasations of a vesicant can result in significant tissue necrosis. Administration into a large vein is optimal. CVADs are more expensive than a peripheral IV. Dosing depends on the drug. IV chemotherapeutic agents are not administered at home. They are given in an outpatient or clinic setting if not given during hospitalization.

**30.** A patient's central venous access device (CVAD) becomes infected. Why would the physician order antibiotics to be given through the line rather than through a peripheral IV line?

1. to prevent infiltration of the peripheral line
2. to reduce the pain and discomfort associated with antibiotic administration in a small vein
3. to lessen the chance of an allergic reaction to the antibiotic
4. to attempt to sterilize the catheter and prevent having to remove it

(4) Microorganisms that infect CVADs are often coagulase-negative staphylococci, which can be eliminated by antibiotic administration through the catheter. If unsuccessful in eliminating the microorganism, the CVAD must be removed. CVAD use lessens the need for peripheral IV lines and, thus, the risk of infiltration. In this case however, the antibiotics are given to eradicate microorganisms from the CVAD. CVAD use has this effect, but in this case, the antibiotics are given through the CVAD to eliminate the infective agent. The third option would not occur.

**31.** An infection in a central venous access device is not eliminated by giving antibiotics through the catheter. How would bacterial glycocalyx contribute to this?

1. It protects the bacteria from antibiotic and immunologic destruction.
2. Glycocalyx neutralizes the antibiotic rendering it ineffective.
3. It competes with the antibiotic for binding sites on the microbe.
4. Glycocalyx provides nutrients for microbial growth.

(1) Glycocalyx is a viscous polysaccharide or polypeptide slime that covers microbes. It enhances adherence to surfaces, resists phagocytic engulfment by the white blood cells, and prevents antibiotics from contacting the microbe. Glycocalyx does not have the effects in options 2–4.

**32.** Central venous access devices are beneficial in pediatric therapy because:

1. they don't frighten children.
2. use of the arms is not restricted.
3. they cannot be dislodged.
4. they are difficult to see.

(2) The child can move his extremities and function in a normal fashion. This lessens stress associated with position restriction and promotes normal activity. Fear may not be eliminated. All lines can be dislodged. Even small catheters can be readily seen.

**33.** How can central venous access devices (CVADs) be of value in a patient receiving chemotherapy who has stomatitis and severe diarrhea?

1. The chemotherapy can be rapidly completed allowing the stomatitis and diarrhea to resolve.
2. Crystalloid can be administered to prevent dehydration.
3. Concentrated hyperalimentation fluid can be administered through the CVAD.
4. The chemotherapy dose can be reduced.

(3) In patients unable to take oral nutrition, parenteral hyperalimentation is an option for providing nutritional support. High concentrations of dextrose, protein, minerals, vitamins, and trace elements can be provided. Dosing is not affected with options 1 and 4. Crystalloid can provide free water but has very little nutritional benefits. Hyperalimentation can provide free water and considerable nutritional benefits.

**34.** Some central venous access devices (CVAD) have more than one lumen. These multilumen catheters:

1. have an increased risk of infiltration.
2. only work a short while because the small bore clots off.
3. are beneficial to patient care but are prohibitively expensive.
4. allow different medications or solutions to be administered simultaneously.

(4) A multilumen catheter contains separate ports and means to administer agents. An agent infusing in one port cannot mix with an agent infusing into another port. Thus, agents that would be incompatible if given together can be given in separate ports simultaneously.

**35.** Some institutions will not infuse a fat emulsion, such as Intralipid, into central venous access devices (CVAD) because:

1. lipid residue may accumulate in the CVAD and occlude the catheter.
2. if the catheter clogs, there is no treatment other than removal and replacement.
3. lipids are necessary only in the most extreme cases to prevent essential fatty acid (EFA) deficiency.
4. fat emulsions are very caustic.

(1) Occlusion occurs with slow infusion rates and concurrent administration of some medications. Lipid occlusions may be treated with 70 percent ethanol or with 0.1 mmol/mL NaOH. Lipids provide essential fatty acids. It is recommended that approximately 4 percent of daily calories be EFAs. A deficiency can quickly develop. Daily essential fatty acids are necessary for constant prostaglandin production. Lipids are almost isotonic with blood.

**36.** A patient needs a percutaneously inserted central catheter (PICC) for prolonged IV therapy. He knows it can be inserted without going to the operating room. He mentions that, “at least the doctor won’t be wearing surgical garb, will he?” How will the nurse answer the patient?

1. “You are correct. It is a minor procedure performed on the unit and does not necessitate surgical attire.”
2. “To decrease the risk of infection, the doctor inserting the PICC will wear a cap, mask, and sterile gown and gloves.”
3. “It depends on the doctor’s preference.”
4. “Most doctors only wear sterile gloves, not a cap, mask, or sterile gown.”

(2) Strict aseptic technique including the use of cap, mask, and sterile gown and gloves is required when placing a central venous line including a PICC. Options 1, 2, and 4 are incorrect statements. They increase the risk of infection.

**37.** A patient is to receive a percutaneously inserted central catheter (PICC). He asks the nurse whether the insertion will hurt. How will the nurse reply?

1. “You will have general anesthesia so you won’t feel anything.”
2. “It will be inserted rapidly, and any discomfort is fleeting.”
3. “The insertion site will be anesthetized. Threading the catheter through the vein is not painful.”
4. “You will receive sedation prior to the procedure.”

(3) Pain related to PICC insertion occurs with puncture of the skin. When inserting PICC lines, the insertion site is anesthetized so no pain is felt. The patient will not receive general anesthesia or sedation. Statement 2 is false. Unnecessary pain should be prevented.

**38.** What volume of air can safely be infused into a patient with a central venous access device (CVAD)?

1. It is dependent on the patient’s weight and height.
2. Air entering the patient through a CVAD will follow circulation to the lungs where it will be absorbed and cause no problems.
3. It is dependent on comorbidities such as asthma or chronic obstructive lung disease.
4. None.

(4) Any air entering the right heart can lead to a pulmonary embolus. All air should be purged from central venous lines; none should enter the patient.

**39.** A new staff nurse asks her preceptor nurse how to obtain a blood sample from a patient with a portacath device. The preceptor nurse teaches the new staff nurse:

1. the sample will be withdrawn into a syringe attached to the portacath needle and then placed into a vacutainer.
2. portacath devices are not used to obtain blood samples because of the risk of clot formation.
3. the vacutainer will be attached to the portacath needle to obtain a direct sample.
4. any needle and syringe may be utilized to obtain the sample.

(1) A special portacath needle is used to access the portacath device. A syringe is attached and the sample is obtained. One of the primary reasons for insertion of a portacath device is the need for frequent or long-term blood sampling. A vacutainer will exert too much suction on the central line resulting in collapse of the line. Only special portacath needles should be used to access the portacath device.



**40.** What is the purpose of “tunneling” (inserting the catheter 2–4 inches under the skin) when the surgeon inserts a Hickman central catheter device? Tunneling:

1. increases the patient’s comfort level.
2. decreases the risk of infection.
3. prevents the patient’s clothes from having contact with the catheter.
4. makes the catheter less visible to other people.

(2) The actual access to the subclavian vein is still just under the clavicle, but by tunneling the distal portion of the catheter several inches under the skin the risk of migratory infection is reduced compared to a catheter that enters the subclavian vein directly and is not tunneled. The catheter is tunneled to prevent infection.

**41.** The primary complication of a central venous access device (CVAD) is:

1. thrombus formation in the vein.
2. pain and discomfort.
3. infection.
4. occlusion of the catheter as the result of an intra-lumen clot.

(3) A foreign body in a blood vessel increases the risk of infection. Catheters that come outside the body have an even higher risk of infection. Most infections are caused by skin bacteria. Other infective organisms include yeasts and fungi. Options 1 and 4 are complications of a CVAD but are not the primary problem. Once placed, these lines do not cause pain and discomfort.

**42.** The nurse is doing some patient education related to a patient’s central venous access device. Which of the following statements will the nurse make to the patient?

1. “These type of devices are essentially risk free.”
2. “These devices seldom work for more than a week or two necessitating replacement.”
3. “The dressing should only be changed by your doctor.”
4. “Heparin is instilled into the lumen of the catheter to decrease the risk of clotting.”

(4) A solution containing heparin is used to reduce catheter clotting and maintain patency. The concentration of heparin used depends on the patient’s age, comorbidities, and the frequency of catheter access/flushing. Although patients have few complications, the device is not risk free. Patients may develop infection, catheter clots, vascular obstruction, pneumothorax, hemothorax, or mechanical problems (catheter breakage). Strict adherence to protocol enhances the longevity of central access devices. They routinely last weeks to months and sometimes years. The patient will be taught how to perform dressing changes at home.

**43.** The chemotherapeutic DNA alkylating agents such as nitrogen mustards are effective because they:

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

(1) Alkylating agents are highly reactive chemicals that introduce alkyl radicals into biologically active molecules and thereby prevent their proper functioning, replication, and transcription. Alkylating agents have numerous side effects including alopecia, nausea, vomiting, and myelosuppression. Nitrogen mustards have a broad spectrum of activity against chronic lymphocytic leukemia, non-Hodgkin’s lymphoma, and breast and ovarian cancer, but they are effective chemotherapeutic agents because of DNA cross-linkage. Alkylating agents are noncell cycle-specific agents.

**44.** Hormonal agents are used to treat some cancers. An example would be:

1. thyroxine to treat thyroid cancer.
2. ACTH to treat adrenal carcinoma.
3. estrogen antagonists to treat breast cancer.
4. glucagon to treat pancreatic carcinoma.

(3) Estrogen antagonists are used to treat estrogen hormone-dependent cancer, such as breast carcinoma. A well-known estrogen antagonist used in breast cancer therapy is tamoxifen (Nolvadex). This drug, in combination with surgery and other chemotherapeutic drugs reduces breast cancer recurrence by 30 percent. Estrogen antagonists can also be administered to prevent breast cancer in women who have a strong family history of the disease. Thyroxine is a natural thyroid hormone. It does not treat thyroid cancer. ACTH is an anterior pituitary hormone, which stimulates the adrenal glands to release glucocorticoids. It does not treat adrenal cancer. Glucagon is a pancreatic alpha cell hormone, which stimulates glycogenolysis and gluconeogenesis. It does not treat pancreatic cancer.

**45.** Chemotherapeutic agents often produce a certain degree of myelosuppression including leukopenia. Leukopenia does not present immediately but is delayed several days to weeks because:

1. the patient's hemoglobin and hematocrit are normal.
2. red blood cells are affected first.
3. folic acid levels are normal.
4. the current white cell count is not affected by chemotherapy.

(4) The time required to clear circulating cells before the effect that chemotherapeutic drugs have on precursor cell maturation in the bone marrow becomes evident. Leukopenia is an abnormally low white blood cell count. Answers 1–3 pertain to red blood cells.

**46.** Currently, there is no way to prevent myelosuppression. However, there are medications available to elicit a more rapid bone marrow recovery. An example is:

1. Epoetin alfa (Epogen, Procrit).
2. Glucagon.
3. Fenofibrate (Tricor).
4. Lamotrigine (Lamictal).

(1) Epoetin alfa (Epogen, Procrit) is a recombinant form of endogenous erythropoietin, a hematopoietic growth factor normally produced by the kidney that is used to induce red blood cell production in the bone marrow and reduce the need for blood transfusion. Glucagon is a pancreatic alpha cell hormone, which cause glycogenolysis and gluconeogenesis. Fenofibrate (Tricor) is an antihyperlipidemic agent that lowers plasma triglycerides. Lamotrigine (Lamictal) is an anticonvulsant.

**47.** Estrogen antagonists are used to treat estrogen hormone-dependent cancer, such as breast carcinoma. Androgen antagonists block testosterone stimulation of androgen-dependent cancers. An example of an androgen-dependent cancer would be:

1. prostate cancer.
2. thyroid cancer.
3. renal carcinoma.
4. neuroblastoma.

(1) Prostate tissue is stimulated by androgens and suppressed by estrogens. Androgen antagonists will block testosterone stimulation of prostate carcinoma cells. The types of cancer in options 2–4 are not androgen dependent.

**48.** Serotonin release stimulates vomiting following chemotherapy. Therefore, serotonin antagonists are effective in preventing and treating nausea and vomiting related to chemotherapy. An example of an effective serotonin antagonist antiemetic is:

1. ondansetron (Zofran).
2. fluoxetine (Prozac).
3. paroxetine (Paxil).
4. sertraline (Zoloft).

(1) Chemotherapy often induces vomiting centrally by stimulating the chemoreceptor trigger zone (CTZ) and peripherally by stimulating visceral afferent nerves in the GI tract. Ondansetron (Zofran) is a serotonin antagonist that blocks the effects of serotonin and prevents and treats nausea and vomiting. It is especially useful in single-day highly emetogenic cancer chemotherapy (for example, cisplatin). The agents in options 2–4 are selective serotonin reuptake inhibitors. They increase the available levels of serotonin.

**49.** Methotrexate, the most widely used antimetabolite in cancer chemotherapy does not penetrate the central nervous system (CNS). To treat CNS disease this drug must be administered:

1. intravenously.
2. subcutaneously.
3. intrathecally.
4. by inhalation.

(3) With intrathecal administration chemotherapy is injected through the theca of the spinal cord and into the subarachnoid space entering into the cerebrospinal fluid surrounding the brain and spinal cord. The methods in options 1, 2, and 4 are ineffective because the medication cannot enter the CNS.

**50.** Methotrexate is a folate antagonist. It inhibits enzymes required for DNA base synthesis. To prevent harm to normal cells, a fully activated form of folic acid known as leucovorin (folinic acid; citrovorum factor) can be administered. Administration of leucovorin is known as:

1. induction therapy.
2. consolidation therapy.
3. pulse therapy.
4. rescue therapy.

(4) Leucovorin is used to save or “rescue” normal cells from the damaging effects of chemotherapy allowing them to survive while the cancer cells die. Therapy to rapidly reduce the number of cancerous cells is the induction phase. Consolidation therapy seeks to complete or extend the initial remission and often uses a different combination of drugs than that used for induction. Chemotherapy is often administered in intermittent courses called pulse therapy. Pulse therapy allows the bone marrow to recover function before another course of chemotherapy is given.

**51.** Patients undergoing chemotherapy may also be given the drug allopurinol (Zyloprim, Alopurinol). Allopurinol inhibits the synthesis of uric acid. Concomitant administration of allopurinol prevents:

1. myelosuppression.
2. gout and hyperuricemia.
3. pancytopenia.
4. cancer cell growth and replication.

(2) Prevent uric acid nephropathy, uric acid lithiasis, and gout during cancer therapy since chemotherapy causes the rapid destruction of cancer cells leading to excessive purine catabolism and uric acid formation. Allopurinol can induce myelosuppression and pancytopenia. Allopurinol does not have this function.

**52.** Superficial bladder cancer can be treated by direct instillation of the antineoplastic antibiotic agent mitomycin (Mutamycin). This process is termed:

1. intraventricular administration.
2. intravesical administration.
3. intravascular administration.
4. intrathecal administration.

(2) Medications administered intravesically are instilled into the bladder. Intraventricular administration involves the ventricles of the brain. Intravascular administration involves blood vessels. Intrathecal administration involves the fluid surrounding the brain and spinal cord.

**53.** The most common dose-limiting toxicity of chemotherapy is:

1. nausea and vomiting.
2. bloody stools.
3. myelosuppression.
4. inability to ingest food orally due to stomatitis and mucositis.

(3) The overall goal of cancer chemotherapy is to give a dose large enough to be lethal to the cancer cells, but small enough to be tolerable for normal cells. Unfortunately, some normal cells are affected including the bone marrow. Myelosuppression limits the body's ability to prevent and fight infection, produce platelets for clotting, and manufacture red blood cells for oxygen portage. Even though the effects in options 1, 2, and 4 are uncomfortable and distressing to the patient, they do not have the potential for lethal outcomes that myelosuppression has.

**54.** Chemotherapy induces vomiting by:

1. stimulating neuroreceptors in the medulla.
2. inhibiting the release of catecholamines.
3. autonomic instability.
4. irritating the gastric mucosa.

(1) Vomiting (emesis) is initiated by a nucleus of cells located in the medulla called the vomiting center. This center coordinates a complex series of events involving pharyngeal, gastrointestinal, and abdominal wall contractions that lead to expulsion of gastric contents. Catecholamine inhibition does not induce vomiting. Chemotherapy does not induce vomiting from autonomic instability. Chemotherapy, especially oral agents, may have an irritating effect on the gastric mucosa, which could result in afferent messages to the solitary tract nucleus, but these pathways do not project to the vomiting center.

**55.** Myeloablation using chemotherapeutic agents is useful in cancer treatment because:

1. it destroys the myelocytes (muscle cells).
2. it reduces the size of the cancer tumor.
3. after surgery, it reduces the amount of chemotherapy needed.
4. it destroys the bone marrow prior to transplant.

(4) Myelo comes from the Greek word *myelos*, which means marrow. Ablation comes from the Latin word *ablatio*, which means removal. Thus, myeloablative chemotherapeutic agents destroy the bone marrow. This procedure destroys normal bone marrow as well as the cancerous marrow. The patient's bone marrow will be replaced with a bone marrow transplant. Myelocytes are not muscle cells. Tumors are solid masses typically located in organs. Surgery may be performed to reduce tumor burden and require less chemotherapy afterward.

**56.** Anticipatory nausea and vomiting associated with chemotherapy occurs:

1. within the first 24 hours after chemotherapy.
2. 1–5 days after chemotherapy.
3. before chemotherapy administration.
4. while chemotherapy is being administered.

(3) Nausea and vomiting (N&V) are common side effects of chemotherapy. Some patients are able to trigger these events prior to actually receiving chemotherapy by anticipating, or expecting, to have these effects. N&V occurring post-chemotherapeutic administration is not an anticipatory event but rather an effect of the drug. N&V occurring during the administration of chemotherapy is an effect of the drug.

**57.** Medications bound to protein have the following effect:

1. enhancement of drug availability.
2. rapid distribution of the drug to receptor sites.
3. the more drug bound to protein, the less available for desired effect.
4. increased metabolism of the drug by the liver.

(3) Only an unbound drug can be distributed to active receptor sites. Therefore, the more of a drug that is bound to protein, the less it is available for the desired drug effect. Less drug is available if bound to protein. Distribution to receptor sites is irrelevant since the drug bound to protein cannot bind with a receptor site. Metabolism would not be increased. The liver will first have to remove the drug from the protein molecule before metabolism can occur. The protein is then free to return to circulation and be used again.

**58.** The nurse has physician orders to not administer a calcium supplement to a patient if the patient's serum calcium is within the normal range. As the nurse, you must determine whether to give or not give the medication. The following formula can be utilized to calculate the corrected total serum calcium when hypoalbuminemia is present and an ionized calcium value cannot be obtained:

$$\text{corrected total serum calcium} = \text{measured serum calcium} + 0.8 (4.0 - \text{measured serum albumin})$$

The total serum calcium is 7.7 mg/dL, and the measured serum albumin is 2.5 gm/dL. Calculate the answer and determine whether the corrected total serum calcium is normal.

1. 8.9 mg/dL, normal
2. 6.9 mg/dL, normal
3. 2.4 mg/dL, abnormal
4. 13.3 mg/dL, abnormal

(1) A poor correlation between serum ionized calcium and total serum calcium exists particularly when hypoalbuminemia is present. If an ionized calcium value cannot be obtained, the corrected total calcium can be estimated by assuming a normal serum albumin of 4.0 and using the preceding formula. Normal serum calcium levels are 8–10 mg/dL. The value is normal.

**59.** Some drugs are excreted into bile and delivered to the intestines. Prior to elimination from the body, the drug may be absorbed. This process is known as:

1. hepatic clearance.
2. total clearance.
3. enterohepatic cycling.
4. first-pass effect.

(3) Drugs and drug metabolites with molecular weights higher than 300 may be excreted via the bile, stored in the gallbladder, delivered to the intestines by the bile duct, and then reabsorbed into the circulation. This process reduces the elimination of drugs and prolongs their half-life and duration of action in the body. Hepatic clearance is the amount of

drug eliminated by the liver. Total clearance is the sum of all types of clearance including renal, hepatic, and respiratory. First-pass effect is the amount of drug absorbed from the GI tract and then metabolized by the liver; thus, reducing the amount of drug making it into circulation.

**60.** A patient has been taking a drug (Drug A) that is highly metabolized by the cytochrome p-450 system. He has been on this medication for 6 months. At this time, he is started on a second medication (Drug B) that is an inducer of the cytochrome p-450 system. You should monitor this patient for:

1. increased therapeutic effects of Drug A.
2. increased adverse effects of Drug B.
3. decreased therapeutic effects of Drug A.
4. decreased therapeutic effects of Drug B.

(3) Drug B will induce the cytochrome p-450 enzyme system of the liver; thus, increasing the metabolism of Drug A. Therefore, Drug A will be broken down faster and exert decreased therapeutic effects. Drug A will be metabolized faster, thus reducing, not increasing its therapeutic effect. Inducing the cytochrome p-450 system will not increase the adverse effects of Drug B. Drug B induces the cytochrome p-450 system but is not metabolized faster. Thus, the therapeutic effects of Drug B will not be decreased.

**61.** Epinephrine is administered to a patient. The nurse should expect this agent to rapidly affect:

1. adrenergic receptors.
2. muscarinic receptors.
3. cholinergic receptors.
4. nicotinic receptors.

(1) Epinephrine (adrenaline) rapidly affects both alpha and beta adrenergic receptors eliciting a sympathetic (fight or flight) response. Muscarinic receptors are cholinergic receptors and are primarily located at parasympathetic junctions. Cholinergic receptors respond to acetylcholine stimulation. Cholinergic receptors include muscarinic and nicotinic receptors. Nicotinic receptors are cholinergic receptors activated by nicotine and found in autonomic ganglia and somatic neuromuscular junctions.

**62.** A patient has a sudden hypertensive reaction to a newly prescribed medication. The nurse should expect this patient to rapidly exhibit:

1. anginal pain.
2. nausea and vomiting followed by diarrhea.
3. reflex bradycardia.
4. hiccups.

(3) With acute hypertension, baroreceptors in the aortic arch and carotid sinus are stimulated. A vagal (parasympathetic) response occurs with a corresponding decrease in heart rate. This is termed reflex bradycardia. Anginal pain is caused by myocardial hypoxia. Severely elevated blood pressure can cause increased intracranial pressure in patients with loss of cerebral autoregulation resulting in nausea and vomiting. Diarrhea is not part of the process. Hiccups is a spasmodic diaphragm.

**63.** Platelet inhibitors, such as clopidogrel (Plavix) are used to prevent or reduce the frequency of:

1. hemorrhage associated with hemophilia.
2. transient ischemia attacks (TIA), strokes, and myocardial infarctions (MI).
3. subcutaneous ecchymosis.
4. petechia associated with idiopathic thrombocytopenia purpura.

(2) Irreversibly inhibits platelet aggregation; thus, reducing thromboembolic events such as TIAs, stroke, and MI. Platelet inhibitors are not used in any of the conditions in options 1, 3, and 4. Platelet inhibitors may increase the risk of blood loss in patients with these conditions.

**64.** What is the action of a diuretic?

1. to inhibit the production of vasopressin (antidiuretic hormone)
2. to promote diuresis, reduce edema and blood pressure, and improve the symptoms associated with fluid overload
3. to promote aldosterone production
4. diuretics inhibit the reabsorption of sodium, increasing the loss of water

(4) Sodium reabsorption is prevented. Thus, the water that follows sodium will also be excreted. Diuretics do not have this action. Option 2 gives the effects of a diuretic. Diuretics do not promote aldosterone production

**65.** Glucocorticoids are administered to some women in preterm labor. The expected effect of these agents is:

1. to block oxytocin, thus terminating preterm labor.
2. to increase progesterone levels, thus promoting continuation of the pregnancy.
3. to reduce inflammation and infection.
4. to accelerate fetal lung maturation.

(4) The glucocorticoid, betamethasone, is used to prevent respiratory distress syndrome (surfactant deficiency) in the premature infant. It acts by promoting fetal lung maturation in the same manner as endogenous cortisol. Betamethasone is used because it is not highly protein-bound and will readily enter the placental circulation. Glucocorticoids are not used in preterm labor for the processes in options 1, 2, and 3.

**66.** A patient with Parkinson's disease is prescribed an anticholinergic drug. What effect(s) should an anticholinergic agent have on this patient?

1. a reduction in drooling, sweating, tremors, and depression
2. increase the activity of acetylcholine, a neurotransmitter
3. decreases the level of the neurotransmitter dopamine
4. decreased norepinephrine activity

(1) Anticholinergic agents block acetylcholine, an agent that opposes dopamine. One of dopamine's effect is the control of movement and balance. Anticholinergic drugs block the action of acetylcholine. Anticholinergics do not decrease dopamine levels. Anticholinergics do not decrease norepinephrine effects.

**67.** Valacyclovir (Valtrex) is the preferred drug of choice for treating genital herpes because:

1. it is inexpensive.
2. it relieves herpetic pain faster than other antiviral medications.
3. it has relatively no serious side effects.
4. it is approved for usage in all patients above two years of age.

(2) Valacyclovir is rapidly absorbed after oral administration and nearly completely converted to acyclovir by first-pass hepatic effect. Thus, it is rapidly available to prevent viral DNA replication bringing faster relief of symptoms. Valacyclovir is not inexpensive. Valacyclovir can have serious hematologic and hypersensitivity effects. It is approved for use in adults only.

**68.** Oseltamivir (Tamiflu) is given to reduce the duration of influenza A and B. When is it most effective?

1. when started prior to flu season
2. at any time during the infected period
3. within 24 hours of onset of symptoms
4. if flu symptoms do not subside within 5–7 days

(3) The manufacturer recommends initiation as soon as possible at the first appearance of signs and symptoms of infection. Efficacy in clients who begin treatment after 40 hours of symptoms has not been determined. Oseltamivir has not been studied as a prophylactic agent. It is not a substitute for an annual influenza injection.

**69.** The Diabetic Control and Complications Trial showed that tight glycemic control prevented many diabetic sequelae such as nephropathy and retinopathy. Tight control is defined as a HgbA<sub>1c</sub> (A1C) of:

1. adequate values have not been determined.
2. any value that does not induce hypoglycemia.
3. less than 7 percent.
4. any variation between 10 and 12 as long as it is within the range.

(3) The American Diabetes Association and the National Diabetes Education Program strongly recommend an A1C of less than 7 percent. This is also known as glycated hemoglobin or glycosylated hemoglobin and indicates a patient's blood sugar control over the last 2–3 months. A1C is formed when glucose in the blood binds irreversibly to hemoglobin to form a stable glycated hemoglobin complex. Since the normal life span of red blood cells is 90–120 days, the A1C will be eliminated only when the red cells are replaced; A1C values are directly proportional to the concentration of glucose in the blood over the full life span of the red blood cells. A1C values are not subject to the fluctuations that are seen with daily blood glucose monitoring. Recommended values have been established at less than 7 percent.

**70.** Carbidopa-levodopa (Sinemet) is preferred over plain levodopa in the treatment of Parkinson's disease because:

1. it is better absorbed from the GI tract.
2. it induces less CNS adverse effects.
3. it allows more dopamine to reach the brain.
4. it can be administered once a day.

(3) Dopamine does not cross the blood-brain barrier (BBB). Levodopa does cross the BBB where it is converted into dopamine thus increasing the amount of dopamine in the brain. Carbidopa prevents the peripheral breakdown of levodopa, thus further increasing the amount of levodopa crossing the BBB and being converted to dopamine in the brain. Absorption is not a factor. Carbidopa doesn't cross the BBB. Therefore, it does not change the degree of CNS adverse effects of levodopa. Even the sustained release formulation must be given a minimum of twice a day. Usual dosing is 4–8 hours.

**71.** The physician orders the antibiotics ampicillin (Omnipen) and gentamicin (Garamycin) for a newly admitted patient with an infection. The nurse:

1. will administer both medications simultaneously.
2. will give the medications sequentially and flush well between.
3. ask the physician or pharmacy which medication to give first and how long to wait before giving the other drug.
4. start one medication now and begin the other medication in 2–4 hours.

(2) A patient with an infection needs both antibiotics as soon as possible. However, the pH of ampicillin is 8–10 and the pH of gentamicin is 3–5.5, making them incompatible when given together. Flushing well between drugs is necessary. The nurse can determine the correct steps without conferring with the physician or pharmacy. Delaying the second medication by several hours slows the treatment of the patient's infection.



**72.** The intravenous route is potentially the most dangerous route of drug administration because:

1. the IV may infiltrate.
2. it is expensive and nursing intensive.
3. rapid administration of a drug can lead to toxicity.
4. the patient always has more side effects.

(3) The bioavailability of the injected medication is 100 percent and may lead to toxicity. An IV infiltration can cause serious problems with tissue necrosis, but this is not life threatening. Expensive and time consuming do not equate with dangerous. The statement in option 4 is not always true.

**73.** A patient has a 10 percent dextrose in water IV solution running. He is scheduled to receive his antiepileptic drug, phenytoin (Dilantin), at this time. The nurse knows that the phenytoin:

1. will be given after the D10W is finished.
2. should be given at the time it is due in the medication port closest to the patient.
3. can be piggybacked into the D10W solution now.
4. is incompatible with dextrose solutions.

(4) Phenytoin and dextrose will precipitate. Normal saline is used to flush before and after phenytoin administration. The administration of an antiepileptic drug cannot be delayed in order to maintain a therapeutic blood level.

**74.** A 14-year-old patient is admitted with newly diagnosed diabetes mellitus, Type I (juvenile diabetes). He is in diabetic ketoacidosis. The physician orders intravenous insulin administration. The nurse knows the only insulin that can be given IV is:

1. regular.
2. intermediate acting.
3. long acting.
4. none of the above.

(1) Regular insulin is a clear solution and may be given intravenously in intermittent doses or continuous drip infusion. The intermediate-acting and long-acting insulin preparations are suspensions of insulin particles and should never be injected intravenously.

**75.** A nurse needs to start a peripheral IV line on an adult patient. Which of the following sites will she avoid?

1. the antecubital veins
2. placing the IV over a joint
3. the saphenous vein
4. placing the IV in the non-dominant hand

(2) This makes insertion difficult and restricts patient movement of the joint. Attempts by the patient to flex and extend the joint may result in an infiltration. Antecubital veins are used for many IV fluids. An exception is usually chemotherapy. The saphenous vein is an option, especially if the upper extremity veins are unavailable or not indicated. Option 4 permits the patient to use his dominant hand.

**76.** A patient is admitted with a deep vein thrombosis (DVT) in his leg. The physician will order an intravenous infusion of:

1. morphine.
2. a sedative.
3. heparin sodium.
4. a vasodilator.

(3) Heparin is an anticoagulant that inhibits the action of thrombin. It will not dissolve the current clot, but it will prevent the clot from enlarging and prevent the formation of new clots. Pain or discomfort in patients with a DVT can be controlled with milder agents than morphine. The agents in options 2 and 4 are not indicated.

- 77.** A woman pregnant at 36 weeks gestation experiences rupture of the membranes (amnion and chorion) without labor and is hospitalized. Two days later she is febrile. The obstetrician orders an oxytocin (Pitocin) drip started. This medication will:
1. alleviate the discomfort of labor.
  2. reduce her fever.
  3. prevent transference of infection to the infant.
  4. induce labor and promote delivery of the infant.

(4) This agent is a synthetic compound identical to the natural hormone produced in the posterior pituitary gland. It has uterine stimulant effects. Oxytocin will not have the effects in options 1–3.

- 78.** A patient with chronic pain has been taking morphine orally. He needs surgery. Because he will not be able to take oral medications, the physician writes an order to switch the patient's oral medication to the intravenous route at the same dose. The nurse:
1. knows oral and intravenous doses of morphine are not the same.
  2. will give the prescribed dose.
  3. is aware that oral and IV morphine doses are equal.
  4. is hesitant to give the IV morphine because of pending anesthesia.

(1) Orally administered morphine undergoes significant first-pass effect. Oral doses of morphine require 3–6 times the dose of intravenously administered morphine. In this case, the physician must reduce the IV morphine to  $\frac{1}{3}$ – $\frac{1}{6}$  the oral dose. Option 2 will result in an overdose and present serious side effects. The half-life of morphine is 1.5–2 hours. The paperwork that will accompany this patient to the operating room should include notations regarding any medication he has received.

- 79.** A patient is receiving an IV solution of 5 percent dextrose in water with 2 grams of calcium gluconate per liter. The physician orders 4 milliequivalents (mEq) of sodium bicarbonate to be administered IV to treat metabolic acidosis. The nurse:
1. administers the sodium bicarbonate in the medication port closest to the patient.
  2. will give the sodium bicarbonate after the IV fluid is finished.
  3. knows calcium and bicarbonate are incompatible.
  4. piggybacks the sodium bicarbonate into the IV fluid.

(3) Calcium and bicarbonate will precipitate forming calcium carbonate crystals. The action in option 2 will delay treatment of the patient's metabolic acidosis.

- 80.** When a patient is seriously ill, the physician may order certain medications to be administered by the intravenous route. The primary advantage of this route of medication administration over oral dosing is:
1. it is inexpensive.
  2. side effects of the medication are minimized.
  3. nausea and GI discomfort are avoided.
  4. bioavailability of the drug is enhanced.

(4) The bioavailability of the injected medication is 100 percent. Intravenous injection avoids GI absorption and first-pass metabolism issues. The IV route is more expensive than the oral route. IV administration can lead to toxicity. This is not the primary advantage of IV drug administration.

**81.** Many medications given intravenously are initially formulated as sterile powders for reconstitution with sterile liquids at the time the drug is to be injected. What is the purpose of this procedure?

1. It increases the convenience of the product.
2. Refrigeration is not necessary.
3. The medication is better tolerated by the patient.
4. The drug is not stable for long periods of time in solution.

(4) Because of product instability, the powdered form of the drug is reconstituted just prior to administration. The product may actually be less convenient than a product already in solution because of the extra step and time required to reconstitute the powder. The powdered product may not need refrigeration but that is a storage convenience. Reconstitution of a powdered product does not increase tolerance by the patient.

**82.** Giving a medication by the intravenous route is advantageous because:

1. it bypasses the absorption process in the gastrointestinal tract.
2. the risk for toxicity is lower.
3. the intravenous route is less expensive.
4. the bioavailability of the drug is unpredictable.

(1) Absorption in the GI tract is unnecessary. The drug is rapidly distributed via the circulatory system. The risk for toxicity is higher since the entire dose is readily available to the tissues. The intravenous route is more expensive because of the need for an access device, IV tubing, and the syringe with which to administer the drug. The bioavailability of the drug is very predictable at 100 percent.

**83.** Before giving an IV medication, the nurse must check the IV site to ensure the IV is patent without problems. The nurse notices the site and area slightly above it are warm and reddened. The patient reports that the area is tender when touched. This patient is exhibiting:

1. a wheal.
2. thrombophlebitis.
3. erythema.
4. edema.

(2) Irritation or injury to the vein results in a blood clot formation. Symptoms include redness, edema, tenderness, and a surface vein that feels like a cord. A wheal is a raised mark on the skin often caused by an allergic response. Erythema is an abnormal redness of the skin related to vasodilation. Edema is swelling from an accumulation of fluid.

**84.** The nurse can ensure the IV is patent prior to administering a medication to a patient by:

1. asking the patient whether he is experiencing any discomfort at the IV site.
2. loosening the tape holding the IV device.
3. flushing the IV with 3 milliliters of normal saline.
4. disconnecting the IV tubing to see whether blood is able to back up into the IV catheter.

(3) Flushing the IV and observing for any abnormal signs such as rapid swelling or blanching of the site can ensure patency of the IV. The patient may not be experiencing discomfort even if the IV is not patent. The procedure in option 2 does not check for patency. Disconnecting the IV tubing opens a sterile line and may allow microbes to enter the tubing. Blood backing up to the catheter may form a clot.

**85.** Distribution of a drug to various tissues is dependent on the amount of cardiac output received by each type of tissue. Which tissue would receive the highest amount of cardiac output and, thus, the highest amount of drug?

1. the skin
2. adipose tissue
3. skeletal muscle
4. the myocardium

(4) Highly perfused tissue includes the brain, heart, kidneys, adrenal glands, and liver. The skin and adipose tissue are poorly perfused while the skeletal muscle is better perfused.

**86.** The primary organ for drug elimination is the:

1. skin.
2. lungs.
3. kidney.
4. liver.

(3) Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.

**87.** A patient needs to rapidly achieve a therapeutic plasma drug concentration of a medication. Rather than wait for steady state to be achieved, the physician will order:

1. a maintenance dose.
2. a loading dose.
3. a medication with no first-pass effect.
4. the medication to be given intravenously.

(2) A loading or priming dose will rapidly establish a therapeutic plasma drug level. It can be calculated by multiplying the volume of distribution by the desired plasma drug concentration. A maintenance dose will maintain a therapeutic level after the loading dose. It will take five drug half-lives to achieve steady state if no loading dose is given. Option 3 is similar to a maintenance dose. Intravenous administration provides excellent drug bioavailability, but one dose will not achieve a therapeutic plasma level.

**88.** The physician orders furosemide (Lasix) 40 mg intravenous push times one dose for a patient in congestive heart failure. A drug reference states that the rate of administration should not exceed 5 mg per minute. Based on this reference, how long should it take the nurse to administer the furosemide?

1. 5 minutes
2. 40 minutes
3. 8 minutes
4. 20 minutes

(3) At 5 mg per minute, it will take 8 minutes to administer a 40 mg dose. Option 1 is too rapid. The nurse will be giving 8 mg per minute. Option 2 is too slow. The nurse will be giving 1 mg per minute. Option 4 is too slow. The nurse will be giving 2 mg per minute.

**89.** The patient receiving medication by inhalation should be placed in what position?

1. prone
2. supine
3. standing
4. sitting

(4) Sitting facilitates patient comfort and compliance. The positions in options 1–3 hamper the administration of the medication and are uncomfortable for the patient, especially if the medication will require several minutes to administer.

**90.** A physician orders a stool softener for a patient. The nurse should consider what factor(s) to promote the action of these laxative agents?

1. Adequate fluid intake is essential.
2. The patient's bowel sounds indicate a degree of peristalsis.
3. The patient's elimination history.
4. What other type of laxative agents has the patient tried without success.

(1) Stool softeners work by drawing water into the stool causing it to soften. Therefore, adequate water intake is necessary to promote the action of the agent. Assessing bowel sounds, obtaining an elimination history, and obtaining a medication history are part of the History and Physical (H&P). This information does not promote the action of the stool softener.

**91.** Prior to administering a medication to a patient, the nurse first checks to ensure the patient has no allergies that would preclude receiving the medication. The nurse:

1. can ask the patient about any known or suspected allergies, including foods.
2. should check with the patient's physician.
3. seeks information from the history and physical section of the chart and the medication administration record.
4. checks the patient for a medic alert bracelet.

(3) These sources contain allergy information. Other sites include the Kardex and the allergy bracelet placed on the patient at admission. Allergies can be discussed with the patient, but the patient may be confused or forgetful. The nurse has access to the same information that the physician does. A medic alert bracelet may or may not contain drug allergy information. Patients may lose their bracelets. They may also transfer someone else's bracelet to themselves if they are agitated or confused.

**92.** The physician orders quinine sulfate 0.8 gram every 8 hours for 3 days for a patient with malaria. Two hundred (200) milligram capsules are available from the pharmacy. The patient will take how many capsules for each dose?

1. 8
2. 4
3. 12
4. 3

(2) Each dose is 0.8 gram or 800 milligrams. Each capsule is 200 milligrams strength. Thus, the patient will need 4 (four) 200 milligram capsules to provide the prescribed dose. Eight capsules would provide 1.6 grams of medication. This would be an overdose. Twelve capsules would provide 2.4 grams of medication. This would be an overdose. Three capsules would provide 0.6 gram of medication. This dose would not be sufficient.

**93.** A patient presents with a cardiac arrhythmia and requires immediate therapy. The goal of antiarrhythmia therapy is:

1. to prevent a myocardial infarction.
2. achieve adequate cardiac output with normal sinus rhythm.
3. to have the patient avoid stressors that might affect his heart rate.
4. to decrease sinoatrial node firing, thus permitting normal electrical conduction through the myocardium.

(2) Normal sinus rhythm and adequate cardiac output will maintain tissue perfusion and meet the body's metabolic demands. The key is "antiarrhythmia therapy." Thus, while preventing a myocardial infarction and preventing stress are desirable in patients, they are not the goal of abnormal rhythm treatment. Slowing the sinoatrial node firing may be a method to control arrhythmias. It is not a goal of therapy.

**94.** An adult patient is febrile. The physician orders aspirin 650 milligrams every 4–6 hours as needed for fever. Aspirin is available in 5 grain tablets. How many 5 grain tablets will the nurse administer to this patient to achieve the prescribed dose?

1. None. Tablets manufactured in grains cannot be utilized when the physician orders a drug in milligrams.
2. None. The nurse must call the physician and obtain an order for aspirin tablets in the correct grain dosage.
3. The nurse knows that 1 grain is equivalent to 65 milligrams. Thus, she would administer two 5-grain tablets to the patient.
4. The nurse would consult the pharmacist.

(3) One grain is equivalent to 65 milligrams. Five grains is 325 milligrams. Two tablets would be an appropriate dose. The actions in options 1–3 are unnecessary since the nurse can appropriately calculate the dose.

**95.** You are teaching your patient about insulin injections. You tell her that the most rapid absorption of insulin is from:

1. any subcutaneous site.
2. the abdomen.
3. the thigh.
4. the arm.

(2) Insulin absorption is most rapid when injected at an abdominal site. Absorption is progressively slower from sites on the arm, thigh, and buttock.

**96.** A diabetic patient calls your clinic and reports her insulin is "clumpy." You advise her to:

1. shake the vial vigorously to re-suspend the insulin particles.
2. warm the vial to room temperature to see whether the clumps disappear.
3. discard the vial and open a new one.
4. gently roll the vial between her hands to re-warm the solution and re-suspend the insulin particles.

(3) Insulin manufacturers recommend that clumped insulin be discarded and a new vial utilized. Agitating and warming the vial will not eliminate clumped material. Minute clumps may remain, which will render the product less effective and promote injection site atrophy.

**97.** Your patient is taking alendronate (Fosamax) for the prevention of osteoporosis. Patient education should include taking the medication:

1. first thing in the morning with a glass of orange juice.
2. at bedtime with a glass of milk.
3. first thing in the morning with water before eating or drinking.
4. then lie down for 30 minutes.

(3) Benefit is seen only when each tablet is taken with plain water the first thing in the morning at least 30 minutes before the first food, beverage, or medication of the day. Juice and milk (calcium) will markedly inhibit absorption. To facilitate delivery to the stomach and reduce irritation of the esophagus, the patient should not lie down for 30 minutes following administration.

**98.** Which of the following type(s) of insulin can be given intravenously?

1. regular
2. intermediate acting
3. long acting
4. none of the above

(1) Regular insulin is a clear solution and may be given intravenously. The intermediate-acting and long-acting insulin preparations are suspensions of insulin particles and should never be injected intravenously.

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

1. solutions administered in obstetrics.
2. diluting antibiotics.
3. large volumes of IV solution.
4. the neonatal and pediatric populations.

(4) Small volumes of medication or fluids are delivered at very slow rates in these groups. The syringe pump allows precise infusion. A syringe pump can be used in almost any setting but is not especially useful in obstetrics. Considerable volumes of fluid administration are limited with the syringe pump. The maximum size syringe the pump will accept is 60 milliliters.

**100.** A 50 milliliter bolus of normal saline fluid is ordered by the physician. He wanted it to infuse in one-half of a hour. The nurse will set the pump rate at:

1. 100 milliliters per hour for one hour.
2. 60 milliliters per hour for one-half hour.
3. 120 milliliters per hour for one hour.
4. 50 milliliters per hour for one hour.

(1) 100 milliliters in one hour equals 50 milliliters in one-half hour (what the physician prescribed). Option 2 is 10 milliliters more than the physician prescribed for one-half hour. Option 3 is the same as option 2; it is 10 milliliters more than the physician prescribed for one-half hour. Option 4 would only provide 25 milliliters over one-half hour or half the volume prescribed.

**101.** In hanging a parenteral IV fluid that is to be infused by gravity, rather than with an infusion pump, the nurse notes that the IV tubing is available in different drop factors. Which tubing is a microdrop set?

1. 15 drops per milliliter
2. 60 drops per milliliter
3. 20 drops per milliliter
4. 10 drops per milliliter

(2) All microdrop sets are calculated to give 60 drops for each milliliter of IV fluid. Macrodrop sets are calculated to give 10, 15, or 20 drops for each milliliter of IV fluid.

**102.** The physician writes an order for a 4 kilogram infant to get an IV fluid at 90 milliliters per kilogram per day by infusion pump. What will the hourly rate of this IV fluid be?

1. 4 milliliters per hour
2. 9 milliliters per hour
3. 15 milliliters per hour
4. 360 milliliters per day

(3) 90 milliliters per kilogram for a 4 kilogram baby is 360 milliliters per day or 15 milliliters per hour. Option 1 is only 24 milliliters per kilogram per day. Option 2 is only 54 milliliters per kilogram per day. The baby should receive the amount in option 4 per day, but the question asks the rate per hour.

**103.** Parenteral fluids that are ordered due to losses from vomiting, diarrhea, or orogastric lavage are called:

1. intermittent fluid.
2. maintenance fluid.
3. continuous fluid.
4. replacement fluid.

(4) Replacement fluid simply replaces lost fluid. Significant GI fluid losses can lead to dehydration, especially in pediatric, elderly, and debilitated individuals. Option 1 is parenteral fluid given at specific intervals. Maintenance fluid meets the body's daily fluid requirement. The administration of continuous fluid is not interrupted.

**104.** The physician orders 1000 milliliters of D5NS for a patient. The nurse will hang:

1. 5 percent dextrose in 0.9 percent sodium chloride.
2. isotonic sodium chloride with 5 grams of dextrose added to the liter bag by the pharmacy.
3. normal saline after she has added 5 grams of dextrose to a liter bag.
4. 5 percent dextrose in any saline solution concentration.

(1) This is the same thing as D5NS (normal saline). Options 2 and 3 are the correct sodium chloride concentration, but the dextrose is 0.5 percent not 5 percent. 50 grams of dextrose should be added to a liter of IV fluid to make D5. Option 4 is the correct dextrose concentration, but any sodium chloride concentration is not normal saline.

**105.** A liter bag of parenteral fluid is running at 125 milliliters per hour. There is approximately 200 milliliters remaining in the bag. It is an hour and one half until change of shift. The nurse should:

1. allow the bag to finish and then hang a new bag of fluid.
2. wait another hour. Discard the bag with 75 milliliters remaining and then hang a new bag of fluid.
3. inform the oncoming nurse that the patient's bag of fluid will run out in just a few minutes and that a new bag will need to be hung.
4. allow the bag to finish, hang a new bag of fluid, and then give report to the oncoming nurse.

(2) This action allows the majority of the parenteral fluid in the current bag to infuse. It eliminates the possibility the fluid will run out during change of shift report; it eliminates the need for the oncoming nurse to immediately go hang another bag; and it eliminates starting the change of shift report late, allowing the off-going nurse to leave on time and the on-coming nurse to get started on time.

**106.** The physician orders parenteral IV fluid for a patient to infuse at 100 milliliters per hour. Using a 10 drop per milliliter macrodrop parenteral fluid administration set, the nurse calculates the drop rate at:

1. 16.6 drops per minute.
2. 10 drops per minute.
3. 17 drops per minute.
4. 33.3 drops per minute.

(3) 100 milliliters at 10 drops per milliliter is 1000 drops per hour or 16.6 drops per minute. However, it is impossible for the nurse to count 6/10 of a drop. Round the calculation to the nearest whole number that can be counted. Option 2 is only 60 milliliters per hour. Option 4 is 200 milliliters per hour.



**107.** A controller is a type of electronic infusion device. The desired flow rate is:

1. the result of positive pressure.
2. determined by the roller clamp.
3. maintained by forcing fluid into the system.
4. dependent on gravity.

(4) A controller depends on gravity to maintain the desired flow rate by a compression/decompression mechanism that pinches the IV tubing, rather than forcing IV fluid into the system. They monitor the selected rate by either drop counting or volumetric delivery. Options 1 and 3 are infusion pumps. Option 2 is a gravity system that does not use an infusion device.

**108.** The concentration of the blood and serum is called osmolarity. An isotonic parenteral solution has the same concentration as blood and serum. An isotonic parenteral solution has a serum osmolarity of:

1. 250–375 milliOsmols per liter.
2. 125–250 milliOsmols per liter.
3. 500–625 milliOsmols per liter.
4. 375–500 milliOsmols per liter.

(1) The normal range for blood and serum osmolarity is 280–320 milliOsmols per liter. The solution in option 2 is hypotonic. The solutions in options 3 and 4 are hypertonic.

**109.** The nurse observes air in the IV tubing of a solution that is infusing into a patient. The nurse:

1. can ignore it if the air volume is less than 5 milliliters.
2. should stop the infusion, purge the air from the line, and then resume the infusion.
3. put an air filter in line to catch future air bubbles.
4. insert a needle in the medication port to vent the air out of the system.

(2) Even small amounts of air entering the venous system can produce a pulmonary embolus. Most pulmonary emboli are the result of blood clots but air, fat, amniotic fluid, and clumps of parasites or tumor cells can obstruct pulmonary vessels. The patient is not safe until the air has been removed from his IV set up and cannot enter his circulation. Option 3 is a useful step in prevent future air emboli. However, the current problem needs immediate attention. The step in option 4 opens the system to room air and may introduce microbes.

**110.** A patient is to receive a liter of normal saline. The physician has ordered it to run over 6 hours. The nurse will set the infusion pump rate:

1. at a rate that is comfortable for the patient.
2. after asking the physician at what rate it should run.
3. at 167 milliliters per hour.
4. at the rate suggested by the pharmacy.

(3) A liter of IV fluid contains 1000 milliliters. This amount divided by a run time of 6 hours equals 167 milliliters per hour. If the infusion is uncomfortable at the correct rate, the nurse must obtain further orders from the physician. The nurse can calculate this rate without asking the physician or pharmacy for the answer.

**111.** The nurse notices a patient's IV fluids are slightly cloudy. The nurse:

1. will permit the fluids to continue to infuse.
2. knows this is normal with some parenteral fluids.
3. will check the expiration date on the fluids.
4. stops the infusion and hangs a bag of clear solution.

(4) Solutions should be clear; free of cloudiness and particulate matter. Option 2 is not a normal process. A contaminant or precipitate is present. The expiration date should be checked prior to starting a bag of IV fluid to ensure it is not out of date.

**112.** A liter bag of IV fluid is running at 125 milliliters per hour on an infusion pump. How long will this bag of fluid last?

1. It should last 8 hours.
2. It depends on the patient's condition.
3. It depends on the size of the IV catheter.
4. Until change of shift.

(1) A liter is 1,000 milliliters. By dividing 1,000 by 125, the nurse can calculate that the IV fluid should take 8 hours to infuse. Options 2 and 3 do not affect infusion rates; option 4 is irrelevant.

**113.** Narrow therapeutic index medications:

1. are drug formulations with limited pharmacokinetic variability.
2. have limited value and require no monitoring of blood levels.
3. have less than a twofold difference in minimum toxic levels and minimum effective concentration in the blood.
4. have limited potency and side effects.

(3) The therapeutic index is the ratio between the median lethal dose and median effective dose of a drug. It provides a general indication of the margin of safety of a drug. Pharmacokinetics is the process of absorption, distribution, metabolism, and elimination. Narrow therapeutic index drugs require close monitoring since there is often little difference between the desired drug effect and toxicity. Narrow therapeutic index drugs have the potential for severe toxic effects with only slight increases in the dose or slight decreases in elimination.

**114.** The tendency of a drug to combine with its receptor is called:

1. potency.
2. efficacy.
3. kinetics.
4. affinity.

(4) Affinity is a close relationship, mutual attraction, or similarity—the tendency of a drug to combine with its receptor. Affinity is a measure of the strength of the drug-receptor bonding. The terms in options 1 and 2 describe the ability of the drug to produce the desired effect. Kinetics is the branch of science that deals with the effects of forces upon the motions of material bodies or with changes in a physical or chemical system.

**115.** The factor that most determines drug distribution is:

1. vascular perfusion of the tissue or organ.
2. salt form.
3. drug interactions.
4. steady state.

(1) Drugs are distributed via the circulatory system. Adequate perfusion is necessary for distribution of a drug. Options 2–4 are not as dependent on adequate perfusion.

**116.** When the amount of drug eliminated in a set amount of time is directly proportional to the amount of drug in the body, the \_\_\_\_\_ pharmacokinetic model is being utilized.

1. zero order
2. one compartment
3. first order
4. two compartment

(3) Most drugs exhibit first-order kinetics, in which the rate of drug elimination is proportional to the plasma drug concentration. Zero-order kinetics is when the rate of drug elimination is constant and is independent of the plasma drug concentration. One compartment drugs distribute to the extracellular fluid. Two compartment drugs distribute to the extracellular and intracellular fluid.

**117.** Which of the following factors will affect a patient's response to a drug without an alteration in serum drug concentration?

1. hepatic or renal dysfunction
2. tolerance
3. drug interactions
4. disease state

(2) Tolerance is an attenuation to the drug. The serum concentration of the drug has not changed. Hepatic or renal dysfunction will alter metabolism and elimination of the drug, thus affecting the serum drug concentration. One drug may affect the serum concentration of another drug by altering metabolism or elimination. The patient's disease state will affect absorption, distribution, metabolism, and elimination of a drug, thus affecting the serum concentration of the drug.

**118.** The fraction of the administered drug that reaches the systemic circulation is:

1. prodrug.
2. absolute bioavailability.
3. first pass effect.
4. free drug.

(2) Bioavailability is the fraction of drug that reaches the systemic circulation in an active form. A prodrug is an inactive compound that is subsequently biotransformed to active metabolites. Drugs absorbed from the intestine reach the liver via the hepatic portal vein before entering systemic circulation. Many drugs are extensively metabolized during their first pass through the liver, reducing the total bioavailability. Free drug is that portion of drug that is not bound to serum proteins.

**119.** The mechanism of action responsible for interfering with the vital processes of micro-organisms of the  $\beta$ -lactam (for example, Penicillin) antibiotics is:

1. inhibition of cell wall synthesis.
2. ribosomal alterations.
3. decreased cell wall permeability.
4. inhibition of protein synthesis.

(1) Penicillin binding proteins (PBP) assemble, regulate, and maintain peptidoglycan strands in the bacterial cell wall. Beta-lactam antibiotics bind to and inhibit the activity of the PBPs. Beta-lactam antibiotics do not affect the processes in options 2 and 4. Beta-lactam antibiotics increase cell wall permeability.

**120.** Drugs are cleared from the body primarily by renal or hepatic routes. Drug clearance is defined as:

1. the volume of distribution.
2. the volume of body fluid from which a substance is removed per unit of time.
3. the half-life.
4. achieving steady state.

(2) Clearance measures the amount of drug removed from a set volume over a set timeframe. The volume of distribution is a virtual volume representing the relationship between the dose of a drug and the plasma concentration of the drug. Half-life is the time necessary to eliminate half of a drug concentration from the body. Steady state is a drug concentration plateau that is reached when the amount of drug entering the body equals the amount of drug being excreted from the body.

**121.** The half-life of a drug is defined as:

1. the renal clearance of the drug.
2. the time required for half of the drug to leave the body.
3. when the amount of drug administered matches the amount of drug excreted from the body.
4. the time half way between doses of the medication.

(2) Half-life is the time required to reduce the drug in the body by half or the time required to reduce the plasma drug concentration by 50 percent. Renal clearance is the amount of drug removed from the plasma by the kidneys over a unit of time. Option 3 is first order kinetics. Option 4 is a time interval and does not provide information on the plasma drug level.

**122.** Which phase of drug action includes the absorption, distribution, metabolism, and excretion of a drug?

1. pharmaceutical phase
2. pharmacokinetic phase
3. pharmacodynamic phase
4. pharmacotherapeutic phase

(2) Pharmacokinetics is essentially “what the body does to the drug”—in other words, how it is absorbed, distributed throughout the tissues, broken down, and eliminated from the body. Options 1 and 4 are not actual drug phases. Pharmacodynamics is essentially “what the drug does to the body”—in other words, what effect the drug elicits.

**123.** The minimum inhibitory concentration (MIC) of an antibiotic is:

1. persistent suppression of microorganism growth after the antibiotic is discontinued.
2. lowest concentration of a drug that kills 99.9 percent of initial microorganism density.
3. the amount of antibiotic that prevents visible growth of microorganisms after 24 hours incubation.
4. the amount of antibiotic needed to prevent emergence of resistant microorganisms.

(3) The MIC is the lowest concentration of a drug that inhibits bacterial growth. Based on the MIC, a particular strain of bacteria can be classified as susceptible or resistant to a particular drug. A persistent antibiotic effect after the antibiotic has been discontinued is called the post-antibiotic affect (PAE). The lowest concentration of a drug that kills 99.9 percent of the initial microorganisms is called the minimum bactericidal concentration (MBC). Option 4 cannot be determined.

**124.** Which phase of drug action includes the absorption, distribution, metabolism, and excretion of a drug?

1. pharmaceutical phase
2. pharmacokinetic phase
3. pharmacodynamic phase
4. pharmacolygenic phase

(3) Pharmacokinetics basically covers “what the body does to the drug.” In other words, it describes the method and rate of drug absorption, how the drug is distributed to the tissues, how the drug is metabolized, and then how it is excreted from the body. 1: There is no such phase. 3: The pharmacodynamic phase basically covers “what the drug does to the body.” In other words, what effect(s) does the drug produce on body tissues and systems. 4: There is no such phase.

**125.** Your patient has liver disease and is receiving a drug that is highly metabolized by the liver. To achieve the usual pharmacodynamic response to the drug, you would expect the drug’s dose to be:

1. greater than a standard dose.
2. smaller than a standard dose.
3. the same as the standard dose.
4. the same as the standard dose, but given more frequently.

(2) The drug cannot be metabolized at the usual rate secondary to liver disease. The dosage must be reduced to prevent drug accretion and toxicity. Giving a larger dose, giving the standard dose, and giving frequent doses would all contribute to toxic levels.

**126.** A patient can receive the mumps, measles, rubella (MMR) vaccine if he/she:

1. is pregnant.
2. is immunocompromised.
3. is allergic to neomycin.
4. has a cold.

(4) A simple cold without fever does not preclude vaccination. Pregnant women and immunocompromised individuals cannot have the MMR vaccine because the rubella component is a live virus and will cause birth defects and disease. The American Academy of Pediatrics states, “Persons who have experienced anaphylactic reactions to topically or systemically administered neomycin should not receive measles vaccine.”

**127.** Levothyroxine (Synthroid) is the drug of choice for thyroid replacement therapy in patients with hypothyroidism because:

1. it is chemically stable, nonallergenic, and can be administered orally once a day.
2. it is available in a single 25mg tablet making dosing simple.
3. it is not a prodrug.
4. it has a short half-life.

(1) It is safe and effective with virtually no side effects when dosed properly. A single daily dose is possible because of the long half-life. Levothyroxine tablets are available in a wide range of concentrations to meet individual patient requirements. Levothyroxine (T4) is a prodrug of T3. Levothyroxine has a long half-life: 7 days.

**128.** Metformin (Glucophage) is administered to patients with Type II diabetes mellitus. Metformin is an example of:

1. an antihyperglycemic agent.
2. a hypoglycemic agent.
3. an insulin analogue.
4. a pancreatic alpha cell stimulant.

(1) This antihyperglycemic agent prevents hyperglycemia by reducing hepatic glucose output and decreasing glucose absorption from the gut. A hypoglycemic drug stimulates insulin production. Metformin is not a type of insulin. Metformin is not a stimulant of any pancreatic cell.

**129.** Patients with Type I diabetes mellitus require treatment with:

1. antihyperglycemic oral agents such as metformin (Glucophage).
2. insulin or an insulin analogue.
3. hypoglycemic oral agents from the sulfonylurea class.
4. an alpha-glucosidase inhibitor such as acarbose (Precose).

(2) Patients with Type I diabetes mellitus have no endogenous insulin production because of pancreatic beta cell destruction and require insulin replacement therapy. Oral agents used to treat Type II diabetes mellitus are not effective in treating Type I disease.

**130.** A patient is hyperglycemic. The physician will order the most rapid-acting insulin available to lower the blood glucose. The physician will choose:

1. insulin lispro.
2. insulin injection (regular insulin).
3. insulin zinc suspension (lente insulin).
4. isophane insulin suspension (neutral protamine Hagedorn [NPH] insulin).

(1) Insulin lispro is almost identical to human insulin and is more quickly absorbed because of less self-association. Regular insulin is absorbed more slowly than insulin lispro because insulin hexamers must dissociate and be absorbed. Lente insulin contains insulin particles combined with a large amount of zinc. This results in an intermediate-acting agent. NPH insulin contains particles of insulin, zinc, and protamine. This results in an intermediate-acting drug.

**131.** Factors that influence the development of antibiotic-resistant bacteria for patients with otitis media include:

1. good patient compliance with antibiotic therapy.
2. appropriate prescribing of antibiotics to treat bacterial infections.
3. overuse of antibiotics for prophylaxis against recurrent infections.
4. prescribing antibiotics that are reasonably priced, effective, and palatable.

(3) Overuse of antibiotics will promote growth of resistant organisms and fungus. Medical organizations recommend antibiotics only for bacterial infections and not for indiscriminate use. Good patient compliance using an appropriate antibiotic that is reasonably priced, effective, and palatable for bacterial infections only will promote eradication of the infection, not bacterial resistance.

**132.** All of the following medications exhibit sympathomimetic effects except:

1. dopamine (Intropin).
2. isoproterenol (Isuprel).
3. methylprednisolone (Solu-medrol).
4. albuterol (Proventil, Ventolin).

(3) Methylprednisolone is an anti-inflammatory agent used in the treatment of hematologic, allergic, inflammatory, neoplastic, and autoimmune conditions. Dopamine stimulates both  $\alpha$  (alpha) and  $\beta$  (beta) adrenergic receptors as well as dopaminergic receptors. Isoproterenol stimulates  $\beta_1$  and  $\beta_2$  receptors resulting in relaxation of bronchial smooth muscle while increasing heart rate and contractility. Albuterol relaxes bronchial smooth muscle by acting on  $\beta_2$  receptors with little effect on heart rate.

**133.** Which mechanism appears to be the principle method for transfer of most clinically relevant drugs across the placenta?

1. active transport
2. simple diffusion
3. pinocytosis
4. facilitated transport

(2) There are a variety of specific transport systems across the placental exchange surface including all of those listed. Research demonstrates that simple diffusion is the most common method. It requires no assistance or energy source. Active transport require an energy source. Pinocytosis is “cell drinking.” Facilitated transport involves carrier molecules and an energy source.

**134.** A 30-year-old woman presents to the obstetrical floor with delivery imminent. She reports no prenatal care and a prior history of several sexually transmitted diseases. Before further information can be obtained, a 2,155 gram infant is delivered without respiratory effort. The infant is suctioned, dried, and stimulated and begins to exhibit gasping respiratory effort. Naloxone (Narcan) is:

1. indicated to facilitate respiratory effort.
2. not indicated because emergent intubation is needed.
3. not indicated due to the possibility of maternal infection.
4. not indicated due to unknown maternal illicit drug status.

(4) Women presenting with no prenatal care and a history of sexually transmitted diseases are suspect for illicit drug usage. Almost all narcotic drugs ingested by the pregnant addict crosses the placenta and enter fetal circulation. Naloxone is an opiate antagonist. Its administration blocks opiate receptor sites and may result in acute withdrawal manifested by immediate bradycardia, hypertension, breathing abnormalities, increased movement and tone, and desynchronized electrocortical activity. If a mother has recently received a narcotic agent for pain relief followed by rapid delivery of the infant, it is possible that the infant’s poor respiratory effort is the result of the maternal narcotic administration. In a controlled case such as this, naloxone can be used to block the narcotic effect and promote the infant’s respiratory effort. Emergent intubation is not routinely the first step in stabilizing an infant at delivery. Naloxone has no effect on infectious processes.

**135.** Antihistamines have what effect on target cells in the skin and mucosa?

1. They decrease production of histamine.
2. Antihistamines prevent the release of histamine from mast cells.
3. Antihistamines block immunoglobulin E (IgE).
4. They block the H1 receptor and act as a competitive receptor antagonist.

(4) The H1 antihistamines have a side chain that resembles histamine permitting the antihistamine to bind to the receptor and act as a receptor antagonist. Antihistamines do not prevent histamine production or release. Histamine is stored in mast cell vesicles and released when IgE causes degranulation.

**136.** Your patient has recently had a bone marrow transplant and is currently being treated for disseminated herpes infection with high dose IV acyclovir (Zovirax). He wants to know why he cannot take acyclovir orally and go home. What is your response?

1. You are too sick to go home.
2. Oral acyclovir is not well absorbed and cannot adequately treat your infection.
3. You can. I’ll ask the doctor to switch your medicine to oral tablets.
4. Oral acyclovir would further irritate your oral lesions.

(2) Oral acyclovir has a relatively low bioavailability (22 percent). Absorption is slow from the GI tract. Immuno-compromised patients with disseminated herpes require predictable blood levels for effective therapy. Option 1 is not a therapeutic response. Option 3 is erroneous patient information. Acyclovir may cause nausea and vomiting but is not routinely associated with oral lesions.

**137.** Empiric antibiotic therapy is:

1. a cause of microorganism resistance.
2. reserved for immunocompromised patients.
3. started immediately after cultures are obtained.
4. costly with undesirable side effects and seldom utilized.

(3) Infections cause significant morbidity and mortality. When an infection is suspected or present, cultures are obtained to determine the exact cause of the infection. Antibiotics are often initiated to prevent sepsis before the culture results are known. This practice is called empiric therapy as is based upon experience, observation, and likely infectious agent. Bacterial resistance is not increased with empiric therapy. Empiric therapy is used for any patient when it is deemed necessary. Empiric therapy is often utilized and is not cost prohibitive.

**138.** Antiretroviral agents in the fusion class, such as enfuvirtide (Fuzeon), inhibit HIV viral replication by:

1. fusing the intracellular contents rendering them harmless.
2. inhibiting the fusion of HIV positive cells to each other permitting macrophages to move in to phagocytose the positive cell.
3. fusing the HIV positive cell with a killer T cell.
4. inhibiting the HIV virus from fusing with a normal cell.

(4) Fusion drugs inhibit the fusion of viral and cellular membranes. Options 1–3 are not actions of the fusion class of antiretroviral agents to treat HIV.

**139.** Medications still in the clinical trial process can be utilized in certain patients with life-threatening illness. This action is called:

1. compassionate usage.
2. expedited availability.
3. high alert availability.
4. phase IV clinical trial provision.

(1) An agent not approved for general use and still in the clinical trial process may have deleterious effects on humans. However, if the healthcare team determines that the patient will likely not survive or will experience extreme morbidity without the drug, a process can be initiated where the manufacturer releases a set amount of drug to the physician. Expedited availability occurs when a drug is rushed through development and clinical trials in an effort to make it rapidly available. High alert drugs are those with substantial risk of morbidity and mortality. Phase IV clinical trials regard ongoing data collection about a drug after it has FDA approval and is marketed to the public.

**140.** A chemical reaction between drugs prior to their administration or absorption is known as:

1. a drug incompatibility.
2. a side effect.
3. an adverse event.
4. an allergic response.

(1) This occurs most often when drug solutions are combined before they are given intravenously but can occur with orally administered drugs as well. Drugs cause the events in options 2–4 after administration and absorption.

**141.** When medications have an additive, synergistic, or antagonistic effect on a tissue, the nurse knows that a \_\_\_\_\_ reaction has occurred.

1. pharmaceutical
2. pharmacodynamic
3. pharmacokinetic
4. drug incompatibility

(2) Pharmacodynamics pertain to the effect of the drug on receptors. Pharmaceutical reactions are chemical reactions between drugs prior to administration or absorption. Pharmacokinetic reactions refer to the body's effect on the drug. Drug incompatibilities are another term for pharmaceutical reactions.



**142.** One drug can alter the absorption of another drug. One drug increases intestinal motility. What effect will this have on the second drug?

1. None; absorption of the second drug is not affected.
2. The increased gut motility increases the absorption of the second drug.
3. The absorption of the second drug cannot be predicted.
4. Less of the second drug will be absorbed.

(4) Since most oral medications are absorbed in the intestine, increased motility moves the second drug through the system faster, thus decreasing the absorption time and the amount taken up by the intestine.

**143.** Enterohepatic cycling of some drugs can be significantly reduced when which of the following classes of drugs is also administered?

1. antihypertensive agents
2. antibiotics
3. antiepileptic drugs
4. antiarrhythmia medications

(2) Enterohepatic cycling is dependent on intestinal bacteria to hydrolyze drug conjugates excreted in bile, thus, enabling the lipid-soluble parent compound to be reabsorbed into circulation. Antibiotics may kill or significantly reduce the bacterial concentration, thus, reducing enterohepatic cycling and plasma drug concentrations. The agents in options 1, 3, and 4 do not affect intestinal bacteria.

**144.** Drug interactions are more likely to occur when:

1. the patient is elderly.
2. the drugs are taken close together.
3. the affected drug has a low therapeutic index.
4. the patient is sedentary.

(3) Low therapeutic index drugs have room for very little margin of error. Their blood levels must remain within a narrow range to be effective and yet prevent toxicity. Age, timing of dosing, and inactive lifestyle don't initiate drug interactions.

**145.** A 56-year-old male is admitted to the coronary care unit with an anterior myocardial infarction. His current drug history includes the use of the beta blocker propranolol (Inderal). The physician orders lidocaine to be "on standby." The nurse knows that:

1. concurrent usage of propranolol with lidocaine can precipitate lidocaine toxicity.
2. beta blockers can precipitate tachycardia.
3. lidocaine will reverse the effects of propranolol.
4. propranolol competes with lidocaine receptor sites.

(1) Propranolol reduces the metabolism of lidocaine. Toxic effects include cardiovascular collapse, convulsion, and respiratory depression or arrest. Beta blockers reduce sympathetic stimulation of the heart producing negative chronotropic, inotropic, and dromotropic effects, not an increased rate. Lidocaine does not have this effect. Propranolol blocks beta-adrenergic receptors. Lidocaine inhibits sodium channels.

**146.** A patient is seen in clinic today and diagnosed with iron deficiency anemia. The physician prescribes iron replacement therapy. When discussing administration of the drug, the nurse must educate the patient that:

1. if he has trouble swallowing the tablet, he can chew it.
2. if he forgets his medication for 2 days, he can take the missed doses the next day when he takes that day's regular dose.
3. the medication should be taken 2 hours before or after food.
4. his anemia will be resolved within 7–10 days.

(3) Food decreases iron absorption by up to two-thirds. Iron tablets should not be chewed to prevent staining of the teeth. Taking several days worth of iron supplementation can lead to toxicity with severe morbidity and mortality. In iron-deficient states, the small intestine's absorption of iron is enhanced, but the patient's anemia will not be resolved so rapidly. His iron stores need to be replenished and new red cell production needs to be supported.

**147.** A patient is seen in the clinic with severe anemia. His religious beliefs prohibit the administration of blood products. His physician prescribes epoetin alfa (Epogen, Procrit) therapy. What other agent will the physician likely prescribe?

1. myeloablative therapy
2. a nonsteroidal anti-inflammatory drug
3. an antimetabolite
4. ferrous sulfate (Feosol, Feratab)

(4) Concurrent administration of ferrous sulfate (iron) to patients receiving epoetin alfa therapy increases the likelihood of a positive hematologic response to epoetin alfa. An adequate iron supply must be available for red blood cell production. The agents in options 1 and 3 will cause myelosuppression at a time when enhanced proliferation is desired. The agents in option 2 do not enhance red cell production.

**148.** A 18-year-old female has had epilepsy since childhood and has been maintained relatively seizure free on antiepileptic drugs (AEDs), including carbamazepine (Tegretol) and phenytoin (Dilantin). Today in clinic she asks you about starting oral contraceptives (OCs) as birth control. You educate her that:

1. she should not take oral contraceptives because she is too young.
2. the AEDs she is taking will interact negatively with OCs and could lead to an unplanned pregnancy.
3. her parents will need to be consulted prior to obtaining the OC prescription.
4. introducing OCs will likely trigger seizure activity.

(2) The antiepileptic drugs phenytoin (Dilantin), primidone (Mysoline), carbamazepine (Tegretol), felbamate (Felbatol), and phenobarbital can increase the metabolism of oral contraceptives leading to contraceptive failure. The patient is old enough to make the decision and to take OCs. Parental permission is not required. OCs do not lower blood levels of AEDs.

**149.** An infant with a ventricular septal defect has been maintained on digoxin (Lanoxin) for congestive heart failure. The loop diuretic furosemide (Lasix) was recently added to the pharmacologic regimen to treat symptoms of increasing congestive heart failure. The nurse must be alert for:

1. hypothyroidism.
2. hyperaldosteronism.
3. hypokalemia.
4. hyperinsulinemia.

(3) The loss of electrolytes is a common side effect of diuretic therapy. Loss of potassium can result in digoxin toxicity. The thyroid, adrenal, and pancreatic glands are not affected by this drug combination.

**150.** Your patient takes levothyroxine (Synthroid) for hypothyroidism and warfarin (Coumadin) for deep vein thrombosis prophylaxis. What is the possible interaction between these drugs?

1. There is no interaction.
2. There is an increased risk for bleeding.
3. There is an increased risk for cardiovascular effects from levothyroxine.
4. The warfarin dose may need to be increased to anticoagulate the blood.

(1) These agents work independently and share no interactions. Options 2–4 are not possible interactions.

**151.** Which class of medications to treat hyperlipidemia significantly decreases the absorption of numerous other drugs taken simultaneously?

1. bile acid-binding resins
2. fibric acid derivatives (the fibrates)
3. niacin (nicotinic acid)
4. HMG-CoA reductase inhibitors (the statins)

(1) These agents can bind to digoxin, thyroxine, warfarin, fibrates, and other drugs. This effect is reduced if the resins are taken two hours before or after taking other medications. Fibrates cause blood cell deficiencies and myopathies. Niacin should be avoided in patients with hepatic disorders, peptic ulcers, or diabetes mellitus. The statins may interact with other drugs that are metabolized by the cytochrome P450 system, such as a slight elevation of warfarin levels.

**152.** Your patient is taking the anorexic drug sibutramine (Meridia) to treat obesity. Your patient is also taking the SSRI fluoxetine (Prozac) for depression. You should caution him about which of the following potential drug interactions?

1. serotonin syndrome
2. gastroenteritis
3. seizure
4. hypertensive crisis

(1) Sibutramine works by inhibiting the reuptake of norepinephrine (NE) and serotonin (5HT) resulting in enhanced NE and 5HT activity. Fluoxetine is a selective serotonin reuptake inhibitor, also. Concurrent administration of these agents may precipitate dangerously high levels of serotonin, producing serotonin syndrome manifested by agitation, restlessness, confusion, insomnia, seizures, severe hypertension, and GI symptoms; death may ensue. The symptoms in options 2–4 are part of serotonin syndrome.

**153.** A patient takes digoxin with the loop diuretic furosemide (Lasix). This morning he complains of anorexia and nausea. He vomited once yesterday. What do you recommend for this patient?

1. Contact the physician and obtain an order for a nutritional supplement.
2. Contact the physician for an order to keep the patient NPO for 24 hours.
3. Contact the physician for an order to obtain a serum digoxin level and an electrolyte panel.
4. Contact the physician for an order to obtain a potassium level.

(3) Loop diuretics can cause significant renal potassium losses. Digoxin administration lowers myocardial potassium loss. Together, these factors can lead to hypokalemia, which can precipitate life-threatening arrhythmias. Digoxin toxicity is evidenced by anorexia, nausea, and vomiting as well as visual changes. This patient requires a digoxin level and a potassium level that can be obtained from an electrolyte panel. The electrolyte panel will also provide the physician with a more complete picture of this patient's electrolyte status. The measures in options 1 and 2 provide no data regarding digoxin toxicity or electrolyte status. The measure in option 4 is important but omits the necessary digoxin level information.

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

1. Naloxone (Narcan).
2. Labetalol (Normodyne).
3. Neostigmine (Prostigmin).
4. Thiothixene (Navane).

(1) Naloxone is a opiate antagonist. It combines competitively with opiate receptors and blocks or reverses the action of narcotic analgesics. Labetalol is a beta blocker. Neostigmine is an anticholinesterase agent useful in treating the symptoms of myasthenia gravis, urinary retention, and to reverse nonpolarizing neuromuscular agents such as tubocurarine, metocurine, gallamine or pancuronium after surgery. Thiothixene is antipsychotic agent useful in the management of schizophrenia.

**155.** Local anesthetics block the conduction of pain impulses to the spinal cord. Their duration of action:

1. is always longer than general anesthesia.
2. is determined by the rate of diffusion and absorption at the site of administration.
3. is usually short (10 minutes).
4. varies, depending on the patient's weight.

(2) Diffusion and absorption depend on the chemical properties of the anesthetic and other factors such as local pH and blood flow. Duration may or may not be longer than general anesthesia. Duration may be short if the type of local anesthetic is a short acting agent. Patient weight is not a factor.

**156.** A patient asks a nurse working in a dental office what type of drug will the dentist use to provide anesthesia during the extraction of the patient's wisdom teeth. The nurse knows the dentist will use an anesthetic gas, also known as "laughing gas." This agent is:

1. nitrous oxide.
2. nitrogen.
3. nitric oxide.
4. nitrogen dioxide.

(1) Nitrous oxide produces analgesia and is often used for minor surgery and dental procedures that do not require loss of consciousness. It may also produce a mild euphoria in some patients. Nitrogen is a nonmetallic element that constitutes nearly four-fifths of the air by volume, occurring as a colorless, odorless, almost inert diatomic gas,  $N_2$ , in various minerals and in all proteins. Nitric oxide is a potent vasodilator of vascular smooth muscle. It is produced from L arginine. Nitrogen dioxide is a poisonous brown gas,  $NO_2$ , often found in smog and automobile exhaust fumes.

**157.** It has been known for centuries that extracts of the opium poppy can relieve pain. An example of an opium poppy extract useful in human pain management is:

1. the nonsteroidal anti-inflammatory agents such as ibuprofen (Motrin, Advil) and naproxen (Anaprox, Naprelan).
2. the cyclooxygenase blocker acetyl salicylate.
3. morphine sulfate (Roxonol, Duramorph).
4. the analgesic and anti-inflammatory agent indomethacin (Indocin).

(3) Morphine sulfate is an opioid analgesic. The other agents are all nonsteroidal anti-inflammatory agents that block cyclooxygenase.

**158.** Specific receptors for opioids have been detected in the human brain leading scientists to theorize that the human body must produce an endogenous agent that would react with these receptors. These endogenous products are known as:

1. enkephalins and endorphins.
2. catecholamines.
3. cytoplasmic enzymes.
4. glucuronide.

(1) Three major families of endogenous opioid peptides bond with morphine receptors in the CNS: the enkephalins, endorphins, and dynorphins. Catecholamines are adrenergic receptor agonists. Endogenous catecholamines include norepinephrine, epinephrine, and dopamine. Cytoplasmic enzymes are intracellular products active in metabolism. Glucuronide is formed during conjugation reactions in the liver. This process occurs during drug metabolism.

**159.** A post-operative patient is receiving morphine sulfate via the intravenous route. Analgesia is effective. The physician changes the medication to the oral route at the same dosage. Subsequently, the patient states that he is getting very little pain relief. The nurse realizes that:

1. the patient is becoming dependent on the drug.
2. first pass effect is eliminating much of the oral dose.
3. the patient is exhibiting drug-seeking behavior.
4. tolerance to the medication has developed.

(2) Morphine sulfate is an agent that has significant first-pass effect when administered orally. When switching a patient from intravenous to oral morphine sulfate, the physician must increase the dosage to elicit the same response. The patient is not dependent, seeking drugs, or becoming tolerant. Prolonged usage of morphine may cause development of these conditions. This patient is newly post-operative.

**160.** In patients with severe pain associated with trauma, myocardial infarction, and cancer, the primary analgesic drug(s) of choice for relief is/are:

1. the nonsteroidal anti-inflammatory agents.
2. morphine sulfate.
3. codeine and hydrocodone.
4. methadone.

(2) Morphine is a potent agonist that acts in the CNS to produce analgesia, sedation, euphoria, and inhibition of the cough reflex. Morphine remains the standard of comparison for analgesic drugs. Anti-inflammatory agents block cyclooxygenase production, reducing inflammation and exhibiting a mild analgesic effect. Codeine and hydrocodone are less potent analgesics than morphine. The doses required to obtain maximal analgesia produce intolerable side effects, such as constipation. Although a long-acting synthetic opioid agonist that can be used as an analgesic, it is most often used for opioid-dependent patients to prevent their craving for heroin or other opioids because it does not produce significant euphoria or other reinforcing effects.

**161.** Recently, it has been noted that use of coanalgesic agents, such as antidepressants, are effective in treating chronic pain syndromes. Another class of coanalgesic agents used for chronic pain include:

1. the tricyclic antidepressants, such as amitriptyline (Elavil).
2. the nonsteroidal anti-inflammatory agents such as ibuprofen (Advil, Motrin).
3. the antiepileptic agents such as gabapentin (Neurontin).
4. the antiarrhythmic agent adenosine (Adenocard).

(3) These drugs are useful in treating intermittent lancinating quality pain and continuous, burning neuropathic pain. They act by inhibiting the conduction of pain impulses in the CNS. The key is the question. It asks for another class of agents, not the same class. These drugs are useful for mild to moderate pain but are not coanalgesic agents. Adenosine slows conduction time through the AV node and interrupts the re-entry pathway, thus re-establishing normal sinus rhythm. It has no analgesic effects.

**162.** General anesthesia is administered:

1. to decrease blood loss by vasoconstriction.
2. to eliminate pain production.
3. to block mucous membrane secretion production.
4. to prevent CNS pain perception.

(4) General anesthesia produces unconsciousness and muscle relaxation and prevents sensory cortex perception of pain. General anesthesia does not decrease blood loss. Pain is still produced, but the CNS sensation of pain is blocked. Additional agents may be administered concurrently with general anesthesia to block secretion production.

**163.** The mu opiate receptors in the CNS are located in the pain-modulating centers. Continued administration of opiate drugs:

1. will result in euphoria followed by dysphoria, and physical dependence on the drug.
2. produces no long-term effects on these receptors.
3. inhibits nociceptors in the CNS.
4. causes diaphoresis and increased heart rate and respiratory rate.

(1) The mu opiate receptors induce central analgesia and euphoria. Continued stimulation causes short-lived euphoria and dependency. Nociceptors are located in the periphery, not the CNS. Pain caused the autonomic responses. Withdrawal from opiate agents may also induce these effects.

**164.** Most analgesic meds that are administered orally are absorbed from the:

1. stomach.
2. large intestine.
3. small intestine.
4. mouth.

(3) Some agents are absorbed from the stomach, but the majority are absorbed from the small intestine. The organs in options 1, 2, and 4 absorb very few medications.

**165.** The preferred route of administration of analgesic medications is:

1. intravenous.
2. sublingual/buccal.
3. rectal.
4. oral.

(4) Patients and care providers prefer the oral route when possible. This route can be difficult and expensive. Very few medications can be absorbed via this route. Rectal is an effective route in some cases when the patient is unable to take oral medications.

**166.** Your patient has been on a narcotic analgesic for chronic pain from cancer. The dose she has been receiving is no longer bringing about the same pain relief as it once did. The patient asks you why the medicine doesn't work anymore. You explain to her about:

1. tolerance.
2. potency.
3. receptor agonists.
4. efficacy.

(1) Repeated administration of an opioid agonist will lead to pharmacodynamic tolerance of the drug. Tolerance is primarily due to down-regulation of opioid receptors. Potency is the degree of power or strength. Receptor agonists are

drugs that have both receptor affinity and intrinsic activity (the ability to initiate a cellular effect). Efficacy is the ability to produce a desired effect; effectiveness.

**167.** A patient returns from the recovery room following surgery. The nurse assesses the patient and determines he is in pain and administers an opiate analgesic for pain control. The patient suddenly exhibits respiratory distress and oxygen desaturation followed by decreasing heart rate. The patient's deterioration may be caused by:

1. chest wall rigidity.
2. rapid elimination of anesthetic gases.
3. vagal response.
4. hypothermia.

(1) Opiates cause respiratory depression, hypotension, and chest wall rigidity. This patient experienced chest wall rigidity, which led to respiratory distress and oxygen desaturation. Lack of oxygen then contributed to the decreasing heart rate. These symptoms are not a result of elimination of anesthetic gases. A vagal response results in bradycardia followed by oxygen desaturation. Hypothermia may lead to compromise, but it is not an acute event.

**168.** Which of the following patients should refrain from therapy with the thiazide diuretic hydrochlorothiazide (HCTZ)?

1. a patient with renal impairment
2. a patient with hypertension
3. a patient with diabetes mellitus, Type II
4. a patient with renal calculi (kidney stones)

(3) The thiazide class of diuretics cause metabolic abnormalities such as elevated blood glucose levels. This elevation is caused in part by diuretic-induced potassium deficiency. Hypokalemia reduces the secretion of insulin by pancreatic beta cells thereby increasing plasma glucose levels. Thiazides have been used for many years in patients with these conditions. Thiazides decrease calcium excretion, thus, decreasing the likelihood of renal calculi.

**169.** A patient has a seizure disorder and is receiving an anticonvulsant agent to treat her seizures. She has developed gingival hyperplasia while on anticonvulsant therapy. Which of the following medications is responsible for this side effect?

1. phenytoin (Dilantin)
2. phenobarbital (Luminal)
3. carbamazepine (Tegretol)
4. valproic acid (Depakene)

(1) Phenytoin affects collagen metabolism resulting in gingival hyperplasia. The gums may extend down over the teeth if good dental hygiene is not practiced. Gingival hyperplasia is not a side effect of the drugs in options 2–4.

**170.** A side effect of one of the following hyperlipidemia drug classes is a reduction in the absorption of other oral drugs. Which group has this effect?

1. statins
2. bile acid resins
3. niacin
4. fibrates

(2) Bile acid resins bind to numerous drugs including the fibrates, the anticoagulant warfarin (Coumadin), the thyroid agent thyroxine, and the cardiac glycoside digoxin (Lanoxin). The agents in options 1, 3, and 4 do not interfere with the absorption of other drugs.

**171.** Which class of drugs has the side effect of slowing gastric emptying and blocking intestinal hypermotility and bladder spasms?

1. cholinergic receptor agonists
2. adrenergic receptor agonists
3. cholinergic receptor antagonists
4. adrenergic receptor antagonists

(3) These agents block muscarinic and nicotinic receptors and slow GI and bladder motility. The agents in options 1, 2, and 4 do not have this side effect.

**172.** Metronidazole (Flagyl) is used to treat anaerobic protozoa infections such as *Entamoeba histolytica* (amebiasis), *Giardia lamblia* (giardiasis), and *Trichomonas vaginalis* (trichomoniasis). The nurse should educate the patient that a common side effect of this medication is:

1. sleepiness.
2. tremors.
3. tinnitus.
4. a metallic taste.

(4) This drug produces a metallic taste in a high percentage of patients taking it. The other options are not side effects of metronidazole.

**173.** A patient takes the anticonvulsant carbamazepine (Tegretol). She calls the clinic today and complains of a sore throat and easy bruising. The nurse should advise the patient to:

1. come to the clinic to be seen today.
2. stop taking the drug and make an appointment to be seen next week.
3. continue taking the drug so the blood level will remain stable.
4. increase the intake of green leafy vegetables (vitamin K) and call if symptoms continue.

(1) Aplastic anemia is sometimes the result of carbamazepine. The patient should be seen right away to rule out this disorder. Maintenance of seizure control is also necessary. An evaluation of the patient should not be delayed.

**174.** The physician initiates a systemic glucocorticoid medication for a patient. When performing a dip stick on this patient's urine, the nurse detects glycosuria. What is the association between systemic steroid administration and glycosuria?

1. Renal sodium reuptake and potassium excretion are increased.
2. Hyperglycemia and glycosuria are side effects of glucocorticoid administration.
3. The patient has developed diabetes mellitus, Type II.
4. Renal disease is present.

(2) Glucocorticoids increase gluconeogenesis and decrease peripheral glucose uptake leading to hyperglycemia and glycosuria. These are effects of mineralocorticoids. Diabetes mellitus, Type II is not the only reason for glycosuria. This patient has no indication of renal disease.

**175.** Inhaled glucocorticoids prescribed for treatment of reactive airway disease (asthma) may have local side effects. The most common side effect is:

1. elevated blood glucose level.
2. oral candidiasis.
3. cough.
4. dysphonia.



(4) Dysphonia (hoarseness) occurs in approximately 40 percent of patients. It is caused by a myopathy of the laryngeal muscles that is reversible when the medication is discontinued. An elevated blood glucose level is a systemic effect, not local. Oral candidiasis can occur, but the incidence is reduced if the patient rinses his mouth with water after inhaling the medication. A cough may occur initially, but patients rapidly attenuate.

**176.** When caring for a patient receiving amphotericin B (Fungizone, Amphocin) what laboratory values should be monitored closely?

1. potassium and magnesium
2. sodium and calcium
3. chloride and BUN
4. phosphate and serum creatinine

(1) Significant hypokalemia and hypomagnesemia can occur with amphotericin B administration. Sodium values may drop, and glomerular filtration is reduced.

**177.** Your patient comes to clinic today and is started on simvastatin (Zocor) to treat his high cholesterol. He asks you what side effects he should expect. You tell him simvastatin may cause:

1. GI distress (nausea, diarrhea, dyspepsia).
2. back pain or muscle tenderness.
3. flushing or itching of the skin.
4. a decrease the absorption of other drugs (warfarin, digoxin, levothyroxine).

(2) The HMG-CoA reductase inhibitors, such as simvastatin, lovastatin, pravastatin, atorvastatin, and fluvastatin, can cause myalgia and rhabdomyolysis. Patients should be counseled to report any sign of unusual, diffuse, or persistent muscle tenderness, pain, or weakness. This class of drugs does not have the other effects.

**178.** A 14-year-old with Type I diabetes mellitus has responsibility for taking his insulin. Because of after-school activities today, he takes his entire daily dose of insulin at breakfast. At school, he loses consciousness and has a seizure. The school nurse in the school-based clinic will administer what therapeutic agent while awaiting the Emergency Medical Service arrival?

1. rapid acting regular insulin
2. orange juice
3. glucagon
4. bicarbonate

(3) Glucagon activates glycogenolysis and gluconeogenesis and increases hepatic glucose production. It counteracts hypoglycemic reactions. Regular insulin will make his hypoglycemia worse. If he is unconscious, he cannot drink orange juice. Sodium bicarbonate is useful in treating ketoacidosis. This patient does not have ketoacidosis.

**179.** Bovine and porcine preparations of insulin can result in:

1. diminished insulin antibody production.
2. a significant reduction in insulin requirements.
3. less chance of allergic reactions.
4. lipodystrophy at injection sites.

(4) Bovine and porcine insulin preparations can cause significant atrophy or hypertrophy of subcutaneous adipose tissue at the injection site. This effect is considerably lessened when human insulin is used. Insulin antibody production is triggered by the antigens in animal insulin. Insulin requirements are higher when animal insulin is used because of insulin-insulin antibody binding. Animal insulin can induce allergic responses to the product.

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

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

(1) Fat emulsions are formulated in 10, 20, and 30 percent solutions and supply 1.1, 2, and 3 kilocalories respectively for each milliliter. A milliliter of 5 percent dextrose only supplies 0.17 kilocalories. Fat emulsion are essentially pH neutral and isotonic.

**181.** A complication of total parenteral nutrition (TPN) is the development of cholestasis. What is this condition?

1. an inflammatory process of the extrahepatic bile ducts
2. an arrest of the normal flow of bile
3. an inflammation of the gall bladder
4. the formation of gall stones

(2) Cholestasis due to TPN administration is an intrahepatic process that interrupts the normal flow of bile. Extra-hepatic bile duct inflammation is cholangitis. Inflammation of the gall bladder is cholecystitis. Gall stones are formed by bile components.

**182.** The physician wants to know whether the patient is tolerating his total parenteral nutrition. He orders which of the following laboratory tests?

1. triglyceride level
2. liver function tests
3. a glucose tolerance test
4. a complete blood count

(3) The liver is the primary organ for digestion. Liver function tests measure the blood level of enzymes produced by the liver: prothrombin time/partial prothrombin time, serum glutamic oxaloacetic and pyruvic transaminases, gamma glutamyl transpeptidase, albumin, and alkaline phosphatase. A triglyceride test measures the body's ability to clear triglycerides, the primary component of fats. Failure to clear triglycerides from the bloodstream indicates a problem with storage or the ingestion of too much fat. This test measures the blood glucose at intervals after a glucose-rich solution is ingested. It is used for diagnosing diabetes. This test is used to evaluate blood components.

**183.** In the adult population, total parenteral nutrition (TPN) may be administered for a certain number of hours per day. However, in the neonatal population, typically the solution is ordered to run continuously 24 hours per day. What is the rationale for infusing TPN continuously to neonates?

1. It doesn't interfere with nursing care.
2. Babies don't need nutrition in boluses to mimic meals.
3. All neonates get all IV fluids on a continuous basis.
4. It provides a constant energy and fluid source.

(4) Neonates needing TPN have very little energy stores. Thus, TPN must be provided on a continual basis to meet metabolic demands and fluid requirements (prevent dehydration, prevent over hydration by giving fluids within a short period of time). Part of nursing care includes the administration of prescribed TPN. Option 2 is unknown. It is being studied. All babies do not receive all IV fluid continuously. Infusion depends on the infant, the infusate, and the purpose to be achieved.

**184.** Which of the following facts about total parenteral nutrition (TPN) is true?

1. It is expensive.
2. Complications are very rare.
3. Hospitalization is required while receiving TPN.
4. It has few uses in modern medicine.

(1) TPN solution preparation requires special airflow equipment and personnel. The administration set and infusion pump are a cost factor. Placement and maintenance of an IV line is another. Overall, the TPN process is quite expensive. Complications occur and include infection, liver disease, nutritional issues, metabolic problems, and mechanical problems related to the IV catheter. Many patients are maintained on TPN in setting other than the hospital, including home. Enteral nutrition is always optimal. When the body's metabolic requirements cannot be met enterally, TPN can be life saving. It is used for malnutrition, GI disease/anomalies, and when the patient can't/won't eat.

**185.** A patient has been receiving chemotherapy to shrink a thoracic tumor. Chemotherapeutic side effects have made eating difficult. The date for surgical removal of his tumor is approaching. Why would the physician initiate total parenteral nutrition (TPN) at this point?

1. He wouldn't. TPN will cause the tumor to grow.
2. To treat malnutrition and optimize the surgical outcome.
3. Because the patient is depressed about his cancer and the chemotherapy side effects.
4. It is the standard of all surgeons to initiate TPN prior to surgery.

(2) Patients with optimal nutritional status have improved outcomes in fighting cancer, withstanding the surgical procedure, healing after surgery, and maintaining energy/activity levels. Option 1 is controversial and is under investigation. Some oncologists recommend that patients not take anti-oxidants that could counter the effect of some chemotherapy. TPN will not cure depression. All surgeons do not administer TPN prior to all surgeries.

**186.** A patient has inflammatory bowel disease and has lost approximately 20 percent of his prior body weight. The physician initiates total parenteral nutrition (TPN). The patient asks the nurse whether he will have to remain hospitalized to receive TPN until he regains the weight. The nurse responds:

1. "Yes. The doctor has to ensure you are stable."
2. "You will have to ask your doctor that question."
3. "Many times patients can be managed on TPN at home."
4. "Probably. It would not be safe to discharge you with home TPN."

(3) Once stable, the physician can discharge the patient with home TPN. Hospitalization is expensive. Many home health agencies and pharmacies handle home TPN. Studies have shown home therapy is safe if managed correctly. The nurse can answer this question, so the physician does not have to be asked.

**187.** A patient is receiving total parenteral nutrition (TPN). Today the physician orders an electrolyte panel. What would this laboratory test be used for in a patient on TPN?

1. It wouldn't. A more appropriate test would be liver function studies.
2. It gives the physician a picture of the patient's renal status.
3. It provides information on the patient's ability to manage the glucose load in his TPN.
4. The physician can adjust the TPN solution electrolytes to meet the patient's needs.

(4) The electrolytes sodium, potassium, chloride, acetate, calcium, phosphorus, and magnesium are TPN components for most patients. An electrolyte panel allows the physician to make adjustments to the TPN recipe to meet the patient's needs. Liver function tests are done to assess the effect of TPN on the liver. Some electrolyte panels contain some renal information such as creatinine, an indicator of glomerular filtration, but it does not provide a complete renal status picture. Some electrolyte panels contain a serum glucose value. It does not provide sufficient information to determine the patient's ability to handle glucose.

**188.** A patient has been receiving total parenteral nutrition (TPN) therapy at home. Today he calls the clinic nurse and reports his next bag of TPN contains small white particles floating throughout the solution. The nurse:

1. instructs the patient to discard the bag and use only clear solutions.
2. tells the patient that this is normal; it is a reaction between the calcium and the phosphorus.
3. instructs the patient to warm the fluid in the microwave until the crystals are dissolved.
4. tells the patient it is safe to use as long as the expiration date has not been reached.

(1) Solutions should be clear, free of cloudiness and particulate matter. The calcium and phosphorus must be mixed at a ratio that prevent precipitation. The pharmacist mixing the TPN calculates this ratio to prevent precipitation. This procedure will not dissolve a precipitate and is dangerous.

**189.** A patient is started on total parenteral nutrition (TPN). The physician orders blood glucose checks every 8 hours. What is the rationale for these checks?

1. to determine whether the patient is developing diabetes mellitus, Type II
2. to evaluate patient tolerance of the glucose infusion rate of the TPN
3. to allow the addition of insulin to the TPN if hyperglycemia occurs
4. to prevent dehydration caused by an osmotic overload caused by hyperglycemia

(2) The physician must know how the patient is tolerating the amount of glucose in the TPN so that a decision can be made to increase the calories by adding more glucose. TPN does not induce Type II diabetes mellitus. Insulin may be added to TPN to prevent hyperglycemia. However, the physician must first know how the patient is tolerating the current glucose load. Glycosuria can lead to dehydration as water follows the glucose into the urine. This information is determined by urine tests, not blood glucose checks.

**190.** Your patient has cholestatic liver disease from prolonged total parenteral nutrition administration and hepatic herpes (HSV) infection. What process of pharmacokinetics may be affected by his disease?

1. absorption
2. distribution
3. metabolism
4. elimination

(3) Hepatic disease will impede metabolism of medications. Absorption and distribution will not be affected by hepatic disease. Very few drugs are eliminated in bile (only those with a high molecular weight).

**191.** Which of the following types of patients will likely receive total parenteral nutrition (TPN)?

1. a body builder with a torn ligament
2. a patient who underwent a cholecystectomy
3. a patient with gastroesophageal reflux disease (GERD)
4. a patient with third degree burns

(4) A major burn results in a hypermetabolic state. The amount of nutrition necessary is so high that it cannot be supplied orally. Caloric requirements are tremendous. Protein is required for tissue synthesis. The patients in options 1–3 would not require initiation of TPN.

**192.** A primary complication of total parenteral nutrition (TPN) administration is:

1. infection.
2. that the patient is tethered to an infusion pump.
3. that the risk for hepatic complications is increased.
4. that it requires continuous hospitalization.

(1) TPN is typically infused through a central venous access device. TPN also contains a high concentration of nutrients. Both factors increase the chances of infection. Option 2 is not a complication. Option 3 is not a primary complication. Long-term administration of TPN can be performed in settings other than the hospital, including the home.

**193.** It is common for total parenteral nutrition (TPN) to include the administration of a fat emulsion, such as Intralipid. A fat emulsion is indicated:

1. when the patient has cholecystitis and gall stones.
2. to prevent essential fatty acid deficiency.
3. in patients with atherosclerosis who must limit oral fat intake.
4. for patients with an abnormal lipid profile.

(2) Lipids provide essential fatty acids (EFA). It is recommended that approximately 4 percent of daily calories be EFAs. A deficiency can quickly develop. Daily essential fatty acids are necessary for constant prostaglandin production. The patients in options 1, 3, and 4 do not require fat emulsion infusion.



# Reduction of Risk Potential

This chapter contains questions and answers from the following topic areas:

- Diagnostic Tests
- Laboratory Values
- Monitoring Conscious Sedation
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests/Treatments/Procedures
- Potential for Complications of Surgical and Health Alterations
- Therapeutic Procedures
- Vital Signs

**1.** Which chart entry regarding a bone scan reveals the nurse has correctly documented client teaching?

1. Client taught about bone scan. Has no questions about it.
2. Client does not speak English. Unable to do any teaching.
3. Client taught preparation for bone scan. Verbalizes understanding.
4. Client instructed bone scan scheduled for 1 PM. No questions asked.

**(3)** This statement is more specific and indicates that the client provided feedback indicating understanding. Options 1 and 4 are not correct, as simply not asking questions does not indicate understanding. Option 2 is not correct, because if a client does not speak English, the nurse needs to obtain an interpreter to assist with teaching.

**2.** Which statement by the nurse shows therapeutic communication with the client who expresses fear of having a CT scan done?

1. “Is your problem that you are claustrophobic?”
2. “You don’t need to be so childish about this.”
3. “I had a CT scan done without any problems.”
4. “What is it about having a scan that makes you afraid?”

**(4)** This statement allows the nurse to elicit the reason for the fear and can allow the client to vent. Option 1 makes an assumption, which may not be correct. Options 2 and 3 show a lack of sensitivity to the client’s fear.

**3.** Which item would a nurse need to remove from a client prior to magnetic resonance imaging?

1. plastic ring
2. metal barrette
3. leather bracelet
4. cloth belt

**(2)** All metal objects must be removed prior to magnetic resonance imaging, to prevent the strong magnet from pulling them loose, potentially injuring the client. Since the other objects are not metal, they would not have to be removed.

**4.** Which of the following clients are not a candidate for magnetic resonance imaging?

1. client with a pacemaker
2. client with a porcine heart valve
3. client with an arrhythmia
4. client with an indwelling catheter

(1) Since a pacemaker is metal, a client with one could not undergo MRI, since the strong magnet would interfere with its function. A porcine heart valve is not metal, so it is acceptable. Clients with arrhythmias may need to be monitored, but they can receive an MRI. An indwelling catheter is not a contraindication.

**5.** What is the appropriate response of the nurse to a 20-year-old woman who is anxious about having her first Papincolaou test?

1. "It is not something to get upset about. Calm down."
2. "You are a grown woman. Do not fret about this."
3. "I understand your concern. What worries you?"
4. "Many women your age have this done. Don't worry."

(3) This statement shows empathy with the client and will allow the nurse to determine what worries the client. The other statements are insensitive and will not facilitate trust or a therapeutic relationship with the client.

Questions 6 through 16 relate to this scenario:

Mr. Jones, a 70-year-old African American male, is a client on a medical unit. He is admitted with a lower gastrointestinal bleed. He is scheduled for a colonoscopy today at 1 PM. He has been NPO since midnight as ordered. He received the bowel prep for the colonoscopy, which included a clear liquid diet for 24 hours and a gallon of GoLYTLELY last evening. He has intravenous fluids of 5 percent dextrose and .45 percent saline infusing at 100 cc/hour. He has a history of hypertension and congestive heart failure.

**6.** Which of the following problems is Mr. Jones at risk for developing, due to his medical history and preparation for a colonoscopy?

1. elevated blood sugar
2. fluid overload
3. elevated serum potassium
4. dehydration

(2) The nurse must monitor for fluid overload, since Mr. Jones has a history of congestive heart failure, he drank a gallon of GoLYTLELY last evening, and is receiving intravenous fluids. Option 1 is not a problem, since he has no history of diabetes. Option 3 is not correct; if anything, he may have a decreased serum potassium after eliminating from the bowel prep. Since he is receiving adequate intravenous hydration, option 4 is not a problem.

**7.** What action should the nurse take if Mr. Jones does not have clear fecal results after receiving GoLYTLELY?

1. Notify the physician.
2. Give a soapsuds enema.
3. Document the results.
4. Cancel the test.

(1) The physician should be notified that the fecal results are not clear, so that a laxative, suppository, or tap water enema can be ordered. There will not be adequate visualization for the colonoscopy if the fecal results are not clear. A soapsuds enema is not given prior to a colonoscopy, as it irritates the mucosa and stimulates mucous secretions that may hinder the test. Documenting results or canceling the test will not solve the problem.

**8.** Mr. Jones' blood pressure this morning is 200/110. He usually receives Tenormin (atenolol) 100 mg PO q am. Which of the following actions by the nurse is correct?

1. Give the whole dose of Tenormin.
2. Give only half the dose of Tenormin.
3. Notify the physician of the blood pressure.
4. Monitor the blood pressure for changes.



(3) The nurse must first notify the physician of the blood pressure, to determine whether the physician would like the Tenormin given, even though the current order is for the client to be NPO. The nurse cannot give the whole dose, since the order is for the client to remain NPO. The nurse cannot decide to give half the dose, as this is outside the scope of nursing practice, and the client is NPO. The blood pressure is too dangerously high to monitor for changes.

**9.** Which of the following statements indicates the client understands the procedure for a colonoscopy?

1. "I will lie on my stomach for the test."
2. "I won't receive any sedation for the test."
3. "I don't need to sign a consent form for this test."
4. "A scope will be inserted through my anus."

(4) A scope is inserted through the anus. The other statements are incorrect.

**10.** Which position should the nurse place the client in for best visualization during a colonoscopy?

1. lying on the left side
2. lying on the right side
3. reverse trendelenburg
4. semi-Fowler's

(1) The colon is best visualized with the client in the left side-lying position. The other positions will not afford such visualization.

**11.** Mr. Jones states, "My father died of colon cancer. I am afraid the colonoscopy will show that I have cancer, too." Which statement reflects a therapeutic response by the nurse?

1. "That's ridiculous! It doesn't mean you'll have cancer."
2. "Tell me more about your fear."
3. "So do you want me to have the test cancelled?"
4. "We can always remove the cancer with surgery."

(2) This statement allows the client to ventilate and explore his fears. The other statements do not allow ventilation, and close the client off from further communication.

**12.** After the colonoscopy, Mr. Jones begins to pass a large amount of flatus. What is the appropriate response for the nurse?

1. Notify the physician.
2. Continue to monitor the flatus.
3. Reassure the client this is normal.
4. Give medication to relieve flatus.

(3) It is normal for a large amount of flatus after a colonoscopy, due to air that may be introduced into the large intestine during the exam. It is not necessary to notify the physician, monitor, or give medication, as the flatus will stop after the air has been eliminated.

**13.** While Mr. Jones is recovering from the colonoscopy, his blood pressure drops from 150/88 to 78/52. Mr. Jones becomes unresponsive. What should the nurse do first?

1. Check for a pulse.
2. Open the airway.
3. Recheck the blood pressure.
4. Check for breathing.

(2) Remember your ABCs! A = Airway, B = Breathing, C = Circulation, in that order. It is not necessary to recheck the blood pressure, since he has become unresponsive, which is evidence of a correct low blood pressure reading.

**14.** Mr. Jones' wife wants to come see him in his room after the colonoscopy. She has brought four members of their church congregation with her to pray for Mr. Jones. Which response by the nurse indicates cultural sensitivity?

1. "I will have to check with the charge nurse."
2. "Do you really think prayer will help him?"
3. "Two of you may come into the room at a time."
4. "I can't allow so many visitors."

(3) Prayer is important to many people and may be especially important in the situation of the African American, who often has strong ties to his church congregation. Hospital policy may not allow more than two visitors at a time, but each can take turns. It is not necessary to check with the charge nurse. Statement 2 may close down further communication and trust with the client.

**15.** Which of the following assessments by the nurse could indicate that Mr. Jones was developing fluid overload?

1. shortness of breath
2. poor skin turgor
3. absence of edema
4. no jugular vein distension

(1) Shortness of breath may indicate fluid overload in the lungs, indicative of heart failure. Option 2 is found with dehydration. Presence of edema and jugular vein distension indicate fluid overload.

**16.** The physician informs Mr. Jones that the pathology report from the colonoscopy reveals cancer. Mr. Jones states, "I am afraid I will die of colon cancer like my father." Which is the most appropriate response by the nurse?

1. "There are better treatments for cancer these days."
2. "Tell me more about what makes you afraid."
3. "Chemotherapy and surgery will cure you."
4. "There is a new cancer drug that works wonders."

(2) This statement will facilitate exploration of the client's feelings. The other statements may offer unrealistic reassurance and may destroy trust with the client.

**17.** A colposcopy is used to examine which area of the body?

1. cervix
2. lungs
3. colon
4. liver

(1) A colposcopy is used to examine the cervix, not the other options.

**18.** Which statement by a client indicates adequate understanding of care after a colposcopy?

1. "I can use contraceptive foam tomorrow."
2. "I will place a diaphragm in now."
3. "I will place a pad to absorb the bleeding."
4. "I can have intercourse with my spouse tonight."

(3) A small amount of bleeding is expected, and an absorbent pad can be used. The client is to abstain from intercourse and inserting objects into the vagina until healing of the biopsy site is confirmed.

**19.** Prior to an amniocentesis, what is important for the nurse to instruct the client to do?

1. Do not eat after midnight.
2. Do not drink after midnight.
3. Urinate just before the test.
4. Urinate just after the test.

(3) The client needs to be instructed to urinate just *before* the test, to minimize risk of puncturing the bladder and aspirating urine, instead of amniotic fluid. The client does not have to abstain from food or fluids.

**20.** Which of the following clients is most likely to receive an amniocentesis?

1. a hypertensive 28-year-old woman
2. a healthy 40-year-old woman
3. a depressed 32-year-old woman
4. a healthy 18-year-old woman

(2) An amniocentesis is indicated in women over age 35, with a family history of genetic abnormalities or previous miscarriages. Due to risks of the test, such as spontaneous abortion, premature labor, and infection, the other options due not warrant an amniocentesis.

**21.** Your client, Mrs. Scott, states, "I am so afraid the amniocentesis will show that this baby has Down's syndrome." Which is an appropriate response by the nurse?

1. "Tell me more about your fears."
2. "You can always have an abortion."
3. "Down's children are affectionate."
4. "You can handle it."

(1) This response allows verbalization by the client and instills trust in the nurse. The other statements are insensitive and minimize the client's fears.

**22.** Mrs. Scott is a member of a Catholic church. Due to her religious beliefs, which of the following would likely not be an option for her if her fetus was shown to have Down's syndrome?

1. abortion
2. blood transfusions
3. surgery
4. prayer

(1) Catholic religious beliefs prohibit abortion, but not the other activities.

**23.** Which of the following is a normal color of amniotic fluid?

1. red
2. clear
3. yellow
4. amber

(2) Amniotic fluid is normally clear, not the other colors.

**24.** Mrs. Scott returns to the clinic for her amniocentesis results. The results indicate that her fetus has Down's syndrome. After the physician informs Mrs. Scott of this, she begins to quietly weep. Which of the following is a therapeutic response of the nurse?

1. leaving the room so Mrs. Scott can be alone
2. changing the subject to provide relief
3. gently placing her hand on Mrs. Scott's shoulder
4. playing some music for distraction

(3) Option 3 allows the nurse to be present for Mrs. Scott, while also giving Mrs. Scott space to cry while she has the need. The other responses show insensitivity and will alienate the client.

**25.** When external fetal monitoring is done, which of the following fetal heart rates is considered to be tachycardic?

1. 50 beats/minute
2. 80 beats/minute
3. 120 beats/minute
4. 170 beats/minute

(4) Tachycardia is fast heart rate. Fetal heart rates of greater than 160 beats/minute are considered tachycardic.

**26.** Which of the following conditions may cause accelerations in fetal heart rate?

1. early hypoxia
2. early contraction
3. maternal position
4. maternal obesity

(1) Accelerations in fetal heart rate may be caused by early hypoxia, not the other conditions mentioned.

**27.** All of the following are purposes of internal fetal monitoring except:

1. to monitor fetal heart rate.
2. to determine gestational age.
3. to measure contractions.
4. to evaluate fetal health.

(2) Internal fetal monitoring does not determine gestational age. The remainder of the choices are purposes of internal fetal monitoring.

**28.** To which area of the fetus does the electrode of the internal fetal monitor attach?

1. shoulder
2. foot
3. scalp
4. chest

(3) The internal fetal monitor attaches to the scalp, not the other selections.

**29.** Which of the following readings from internal fetal heart monitoring indicates fetal head compression?

1. increased variability
2. decreased variability
3. late decelerations
4. early decelerations

(4) Early decelerations are related to fetal head compression and usually indicate a healthy fetus. The other selections do not indicate head compression.

**30.** Which action by the nurse should be taken when fetal heart patterns indicate fetal distress?

1. Turn the mother on the right side.
2. Turn the mother on the left side.
3. Place the mother in trendelenburg.
4. Place the mother in lithotomy.

(2) Turning the mother on the left side may alleviate supine hypotension. The other positions will not provide this effect.

**31.** When internal fetal monitoring reveals decreased uterine pressure, which medication may be required?

1. oxytocin
2. epinephrine
3. enalapril
4. ephedrine

(1) Oxytocin is a uterine stimulant, which may increase uterine pressure. The other medications are used for other conditions.

**32.** While providing internal fetal monitoring, the mother states, "I am so scared that this baby will be stillborn like my other one was." Which of the following is an appropriate response by the nurse:

1. "I'll make sure that doesn't happen."
2. "This monitor will prevent that."
3. "Equipment is better these days."
4. "Tell me more about what scares you."

(4) This is the most therapeutic statement and will allow the mother to explore and ventilate her fears. The other statements may provide false reassurance.

**33.** After applying a fetal heart monitor, it is discovered that the fetus has no heartbeat. The physician tells the mother that her baby has died. Which response by the nurse is most therapeutic?

1. reassuring the mother that she can have another baby
2. remaining silent and holding the mother's hand
3. bringing the mother's other children into the room
4. setting up equipment for removal of the fetus

(2) This is the most therapeutic response, as silence allows the mother to express her grief or feelings as she wishes. Holding the mother's hand is a nonverbal sign of support and presence. The other responses are not therapeutic for this situation.

**34.** An increased lymphocyte count from a bone marrow biopsy may indicate:

1. folic acid deficiency.
2. aplastic anemia.
3. hemolytic anemia.
4. sickle cell disease.

(2) Aplastic anemia may be indicated by an increased lymphocyte count from a bone marrow biopsy, not the other conditions.

**35.** Which of the following statements by a client indicates adequate understanding of a bone marrow biopsy to obtain a laboratory specimen?

1. "The procedure will take less than five minutes."
2. "I can go for a walk right after the procedure."
3. "I will be given medication to minimize discomfort."
4. "It is okay if the injection site becomes swollen."

(3) The client will be given a local anesthetic to minimize the discomfort of the needle penetrating bone tissue. The procedure generally takes 20 minutes. Bedrest needs to be maintained after the procedure for at least 30 minutes. The client needs to report swelling at the injection site, as it may be an indication of infection.

**36.** Which of the following interventions by the nurse is correct when observing bleeding from the injection site of a bone marrow biopsy?

1. Monitor the bleeding.
2. Document the finding.
3. Notify the charge nurse.
4. Apply pressure to the site.

(4) Pressure needs to be applied to the site in order to stop the bleeding. The other responses will not accomplish this.

**37.** Which of the following conditions warrants conducting iron studies?

1. anemia
2. diabetes
3. pneumonia
4. myocardial infarction

(1) Anemia is a condition that warrants conducting iron studies, not the other conditions.

**38.** Vitamin B<sub>12</sub> (cyanocobalamin) levels may be low in clients with diets deficient in which food?

1. lettuce
2. apples
3. broccoli
4. eggs

(4) Vitamin B<sub>12</sub> is found in milk, eggs, and animal proteins, not the other responses.

**39.** A client may have a low folic acid level if his diet is deficient in what food?

1. spinach
2. eggs
3. oranges
4. bananas

(1) Folic acid is found in dark green, leafy vegetables, such as spinach, not the other responses.

**40.** Oral intake of which of the following may cause decreased folic acid levels?

1. milk
2. alcohol
3. orange juice
4. coffee

(2) Alcohol is a folic acid antagonist. The other responses are not.

**41.** Ingestion of which of the following medications may cause decreased folic acid levels?

1. Cardizem (diltiazem)
2. Rocephin (ceftriaxone)
3. Dilantin (phenytoin)
4. Betapace (sotalol)

(3) Anticonvulsants, such as Dilantin, are folic acid antagonists. The other responses are not.

**42.** Which of the following values for an adult hemoglobin level should the nurse immediately call to the physician?

1. 19 mcg/dl
2. 16 mcg/dl
3. 12 mcg/dl
4. 9 mcg/dl

(4) A normal hemoglobin level for adults is between 12–18 mcg/dl. 9 mcg/dl is dangerously low. 19 mcg/dl is slightly high, but does not need to be called immediately to the physician.

**43.** An increased hematocrit may be found in which of the following conditions?

1. hemodilution
2. dehydration
3. blood loss
4. anemia

(2) Dehydration can cause elevated hematocrit levels. The other conditions may cause decreased hematocrit levels.

**44.** Red blood cell indices are useful for classifying which types of disorders?

1. cancers
2. infections
3. anemias
4. fractures

(3) Red blood cell indices classify types of anemias, not the other conditions.

**45.** A client with which suspected disorder might undergo hemoglobin electrophoresis?

1. sickle cell disease
2. leukemia
3. pneumonia
4. electrocution

(1) Hemoglobin electrophoresis can distinguish between sickle cell disease and sickle cell trait. It is not conducted for the other conditions.

**46.** An adult client who you are about to draw blood from states, “I think I’m going to pass out when you draw my blood.” What is the best response of the nurse?

1. “Only children get upset by seeing needles.”
2. “Try thinking of a pleasant scene from nature to relax you.”
3. “Don’t look at the needle, and you will be fine.”
4. “This will only take a moment to do.”

(2) Distraction is a useful means of assisting the client to relax. The other statements are insensitive to the needs of the client.

**47.** A client who is a Jehovah’s Witness has just been informed of a low hemoglobin, with an order from the physician to transfuse two units of packed red blood cells. The client refuses to receive the units, based on religious beliefs. What is the appropriate response of the nurse?

1. “You aren’t serious, are you?”
2. “You may die if you don’t get some blood.”
3. “You have the right to refuse the blood.”
4. “I am required to give you this blood.”

(3) The client has the right to refuse receiving blood, and in fact, has the right to refuse any treatments or medications. The other statements are insensitive to the client’s needs.

**48.** What documentation is *best* for the nurse in the case of a client who refuses a blood transfusion?

1. Have the client sign a refusal form.
2. Document the client’s refusal.
3. Chart notification of the charge nurse.
4. Document a quote from the client.

(1) Agencies have a refusal form for the client to sign in the event of refusal of a blood transfusion. This is a better choice than the other responses, although the other responses may also be valuable.

**49.** Which of the following conditions may cause an increased erythrocyte sedimentation rate (ESR, sed rate)?

1. congestive heart failure
2. lupus
3. polycythemia vera
4. salicylate toxicity

(1) Lupus is a collagen disorder, which may increase the sed rate. The other options may decrease sed rate.

**50.** Which of the following conditions may cause an increase in the white blood cell (WBC) count?

1. glaucoma
2. dementia
3. pneumonia
4. atrial fibrillation

(3) WBC count is elevated with infectious processes, such as pneumonia. The other conditions do not have an increased WBC.



**51.** Which of the following describes a shift to the left in the white blood cell (WBC) count?

1. an increase in granulocytes
2. an increase in bands
3. an increase in monocytes
4. an increase in eosinophils

(2) An increase in immature neutrophils, such as bands, is a shift to the left. The other options are mature types of WBCs.

**52.** For the client with a white blood cell count (WBC) less than 1,000, which sign should the nurse be vigilant in assessing?

1. hypotension
2. hypertension
3. bradycardia
4. fever

(4) The client with such a low WBC cannot fight infection well, and a fever could indicate the development of such a problem. The other options are not indicative of a low WBC.

**53.** Which cell type is elevated in the client with severe burns?

1. neutrophils
2. bands
3. basophils
4. eosinophils

(1) Neutrophils are increased in conditions with tissue necrosis, such as burns, not the other cell types.

**54.** Which cell type is elevated in the client with leukemia?

1. neutrophils
2. bands
3. basophils
4. neutrophils

(3) Basophils are increased with leukemia, not the other cell types.

**55.** Which cell type is elevated in the client with asthma?

1. lymphocytes
2. monocytes
3. basophils
4. eosinophils

(4) Eosinophils are increased in asthma, not the other cell types.

**56.** Which cell type is elevated in the client with Hodgkin's disease?

1. lymphocytes
2. monocytes
3. basophils
4. eosinophils

(1) Lymphocytes are increased with Hodgkin's disease, not the other cell types.

**57.** A client with a seizure disorder takes Dilantin (phenytoin) to control seizures. A white blood cell count (WBC) is done, and it is discovered that the client has a low neutrophil count. What conclusion may the nurse make?

1. The blood specimen needs to be redrawn.
2. The neutrophil count may not indicate a disease.
3. The physician needs to be notified immediately.
4. The client has developed an infection.

(2) Dilantin (phenytoin) may decrease the neutrophil count, so it may not be an accurate indication of a disease process. There is no indication for a blood redraw or to notify the physician immediately. A high neutrophil count would indicate an infection.

**58.** Which type of precautions would the nurse take for the client with a white blood cell (WBC) count less than 1,000?

1. isolation
2. reverse isolation
3. respiratory isolation
4. skin precautions

(2) The client is placed in reverse isolation, since they will not be able to fight infection with such a dangerously low WBC. The other options are not correct, as the client does not have an infection that could be passed to others.

**59.** Which of the following statements by a client indicates understanding of strict neutropenic precautions?

1. "I can eat lots of fresh bananas."
2. "I can have imitation plants in my room."
3. "I can eat lots of fresh tomatoes."
4. "I can eat lots of fresh cucumbers."

(2) The client may not have any fresh fruits, fresh vegetables, or live plants. This is because they may be prone to an infection from any insects or bacteria that may be present on them.

**60.** What statement by a visitor indicates adequate understanding of entering the room of a client on neutropenic precautions?

1. "I can bring fresh flowers."
2. "I can bring a fruit basket."
3. "I need to wash my hands."
4. "I do not wear a mask."

(3) Hand washing is the most important way to prevent the spread of infection. Visitors are allowed but need to observe neutropenic precautions, which the other options do not indicate.

**61.** Which statement by the nurse *best* indicates empathy when talking to a client on neutropenic precautions?

1. "Tell me how it feels for you to be in this room alone so much."
2. "This must be a nice break for you to have some time alone."
3. "This probably makes you nervous to be here alone."
4. "I wish I had some time like this to be alone by myself."

(1) This open-ended statement allows the client to vent feelings and indicates empathy by the nurse. The other statements make unwarranted assumptions, or are insensitive.

**62.** A client received testing and was just informed she has leukemia. Which statement by the nurse is *most* therapeutic?

1. "We have treatments for leukemia that are quite effective."
2. "Don't worry, because your type of leukemia is treatable."
3. "Lots of people have leukemia and are successfully treated."
4. "How does it feel for you to hear you have leukemia?"

(4) This statement is most therapeutic, as it allows the client to ventilate her feelings. The ability of the nurse to be present with the client during this difficult time demonstrates caring for the client. The other statements may offer false hope and do not give the client the opportunity to share her feelings.

**63.** An Italian client who is Catholic has just learned that he has leukemia. He asks the nurse to call a priest for him. Which of the following is an appropriate response by the nurse?

1. "Wouldn't you rather speak to a Methodist preacher?"
2. "The call can wait until tomorrow."
3. "I am Baptist, so I cannot call a priest for you."
4. "I will contact a priest for you right away."

(4) This statement reveals cultural awareness and the importance of spirituality in the healing process. The other statements show lack of sensitivity to the client's spiritual needs.

**64.** Which of the following statements by a client being treated for iron-deficiency anemia with iron tablets indicates ability to care for himself?

1. "I will need to have my blood checked regularly."
2. "I can hold my iron pill if I feel good."
3. "If I feel bad, I'll wait until my appointment to tell the doctor."
4. "My stool may turn light brown color."

(1) The client will likely have blood drawn at regular intervals to check red blood cell (RBC) counts. If iron is prescribed, it should not be held but taken as directed. If the client feels poorly, the doctor should be notified immediately, in case the condition has worsened. The stool will turn a dark black color when the client takes iron.

**65.** Which medication may impair platelet aggregation?

1. Lisinopril (Zestril)
2. Protonix (Pantoprazole)
3. Dipyridole (Persantine)
4. Metformin (Glucophage)

(3) Dipyridole may impair platelet aggregation, not the other medications.

**66.** A client with which of the following conditions may receive a unit of platelets?

1. diverticulosis
2. asthma
3. prostatitis
4. lymphoma

(4) A client with lymphoma may have a decreased platelet count that warrants receiving platelets. This is not true of the other conditions.

**67.** Which of the following terms refers to removal of an entire lung?

1. thoracotomy
2. pneumonectomy
3. lobectomy
4. decortication

(2) Pneumonectomy refers to removal of an entire lung, not the remaining pulmonary surgical terms.

**68.** Which of the following findings indicates a flail chest?

1. tracheal deviation to the affected side
2. tracheal deviation to the unaffected side
3. multiple rib fractures on one side
4. paradoxical movement of the chest

(4) Paradoxical movement of the chest indicates a flail chest, not the other findings. Multiple rib fractures do not necessarily create a flail chest. There is no tracheal deviation with flail chest.

**69.** Which structure of the heart is enlarged in the client with cor pulmonale?

1. right atrium
2. left atrium
3. right ventricle
4. left ventricle

(3) The right ventricle is enlarged in the client with cor pulmonale, not the other cardiac structures.

**70.** Which of the following is *not* a cause of chronic obstructive pulmonary disease (COPD)?

1. smoking
2. exercise
3. infection
4. heredity

(2) Exercise is not a cause of chronic obstructive pulmonary disease; the other options are causes of COPD.

**71.** Which of the following nursing interventions may assist the client with chronic obstructive pulmonary disease (COPD) to receive adequate nutrition while conserving energy?

1. Serve small frequent meals.
2. Serve three large meals.
3. Provide steak to eat.
4. Provide raw carrots to eat.

(1) Serving small frequent meals may assist the client with chronic obstructive pulmonary disease (COPD) to receive adequate nutrition while conserving energy. Large meals will tire the client. Steak and raw carrots require too much chewing and will cause the client to become short of breath.

**72.** Cystic fibrosis is most commonly found in which cultural group?

1. Asian
2. Caucasian
3. African American
4. Native American

(2) Cystic fibrosis is most commonly found in Caucasians, not the other cultural groups.

**73.** Which of the following cultural groups has the highest incidence of thalassemia?

1. Asian
2. Hispanic
3. African American
4. Native American

(3) African Americans have the highest incidence of thalassemia of the listed cultural groups. People of Mediterranean origin also have a high incidence of thalassemia.

**74.** Which of the following conditions may lead to anemia?

1. gastritis
2. pneumonitis
3. arthritis
4. tonsillitis

(1) Gastritis may lead to anemia, due to blood loss. The other conditions do not typically involve blood loss.

**75.** Which of the following signs or symptoms would a client with severe anemia *not* exhibit?

1. bradycardia
2. pallor
3. tachypnea
4. headache

(1) The client with severe anemia would have tachycardia, not bradycardia.

**76.** Which of the following statements by a client with iron deficiency anemia indicates adequate understanding of dietary teaching?

1. "I will eat more carrots."
2. "I will eat more bananas."
3. "I will eat more fish."
4. "I will eat more liver."

(4) Liver has high *iron* content. The other foods do not have high iron content.

**77.** By which of the following routes is parenteral iron given?

1. intraosseous
2. intradermal
3. subcutaneous
4. intramuscular

(4) Parenteral iron is given by the intramuscular route, as it can stain tissue. It may also be given intravenously, but not the other routes listed.

**78.** Which of the following surgeries may be performed as treatment for thrombocytopenia?

1. laminectomy
2. cholecystectomy
3. splenectomy
4. appendectomy

(3) A splenectomy may be done as treatment for thrombocytopenia, as a way of increasing the number of platelets in circulation. The other surgeries are not performed for thrombocytopenia.

**79.** Systemic hypertension causes hypertrophy of which part of the heart?

1. right ventricle
2. left ventricle
3. right atrium
4. left atrium

(2) The left ventricle becomes hypertrophied with systemic hypertension, not the other parts of the heart.

**80.** Which of the following statements by a hypertensive client indicates adequate understanding of a low sodium diet?

1. "I will eat less potato chips."
2. "I will eat less tomatoes."
3. "I will eat less fish."
4. "I will eat less apples."

(1) This statement indicates adequate understanding by a hypertensive client indicates of a low sodium diet, because potato chips are high in sodium, not the other options.

**81.** Which of the following is a modifiable risk factor for coronary artery disease?

1. ethnicity
2. obesity
3. gender
4. age

(2) Obesity is a modifiable risk factor for coronary artery disease. The other options are risk factors for coronary artery disease, but they are not modifiable.

**82.** Which mnemonic is used to recall information from a client experiencing chest pain?

1. ABCDE
2. HURTS
3. PQRST
4. HEART

(3) P = precipitating events; Q = quality of pain or discomfort; R = radiation of pain; S = severity of pain; T = timing. The other options are not used.

**83.** Which of the following mnemonics is used to remember the ten most important treatment elements of stable angina?

1. ABCDE
2. HURTS
3. PQRST
4. HEART

(1) A = aspirin, antianginal therapy; B = Beta-adrenergic blocker, blood pressure; C = cigarette smoking, cholesterol; D = diet, diabetes; and E = education and exercise. The other mnemonics are not used.

**84.** Which of the following medications is an angiotensin-converting enzyme inhibitor?

1. Nifedipine (Procardia)
2. Verapamil (Calan)
3. Diltiazem (Cardizem)
4. Captopril (Capoten)

(4) Captopril is an angiotensin-converting enzyme inhibitor. The other options are calcium channel blockers.

**85.** Which of the following actions should a nurse do *first* when she notices that a client with a history of a recent myocardial infarction shows an elevated T wave on his EKG monitor strip?

1. Give aspirin.
2. Call for help.
3. Check the client.
4. Give nitroglycerine.

(3) The client should be checked first, to assess whether there is any distress. The other actions may be done later.

**86.** Which of the following statements by a client indicates adequate understanding of sexual activity after having a myocardial infarction?

1. "I will take a cold shower after sex."
2. "I will eat a large dinner right before sex."
3. "I will not have any foreplay before sex."
4. "I will take nitroglycerine before sex."

(4) This is the correct statement, as use of nitrates prior to intercourse is effective in decreasing angina. The client should avoid hot or cold showers right before or after intercourse. After eating a heavy meal, the client should wait 3–4 hours before having intercourse. Foreplay is desirable, as it allows a gradual increase in heart rate prior to orgasm.

**87.** Which of the following is a sign or symptom of digitalis toxicity?

1. diaphoresis
2. nausea
3. pallor
4. fruity breath

(2) Nausea is a symptom of digitalis toxicity, not the other options.

**88.** Which medication is used for the management of the client with acute pulmonary edema to decrease preload and afterload, as well as minimize anxiety?

1. Hydrocortisone
2. Aminophylline
3. Heparin sodium
4. Morphine sulfate

(4) Morphine sulfate is used for the management of the client with acute pulmonary edema to decrease preload and afterload, as well as minimize anxiety, not the other medications.

**89.** A client's EKG strip shows a PR interval of .28 seconds. The nurse should draw what conclusion?

1. This is a normal PR interval.
2. This is a short PR interval.
3. This is a long PR interval.
4. This is a peaked PR interval.

(3) The normal PR interval is .12–.20 seconds.

**90.** A client has a heart rate of 40 beats/minute. The nurse knows the rhythm is being conducted from what area of the heart?

1. SA node
2. AV junction
3. purkinje fibers
4. right atrium

(2) AV junction conducted rates are 40–60 beats/minute, not the other options.

**91.** For the client with pulseless electrical activity due to hypovolemia, which of the following actions should the nurse do *first*?

1. Administer IV fluids.
2. Administer defibrillation.
3. Administer atropine.
4. Administer epinephrine.

(1) Administering IV fluids should be done *first* for the client with pulseless electrical activity due to hypovolemia. The other interventions may be done later, depending on the client's situation.

**92.** For the client in asystole, which of the following actions should the nurse do *first*?

1. Administer oxygen.
2. Give IV fluids.
3. Give epinephrine.
4. Intubate the patient.

(4) The patient should be intubated first (Airway, Breathing, Circulation). The other actions may be taken afterward.



**93.** A client in the intensive care unit goes into third degree heart block, with subsequent minimal responsiveness, bradycardia, and hypotension. There is no response to IV atropine or epinephrine. What is the appropriate action of the nurse?

1. Administer cardioversion.
2. Give IV Lidocaine.
3. Apply transcutaneous pacing.
4. Give normal saline bolus.

(3) For a client in the intensive care unit that goes into third degree heart block, with subsequent minimal responsiveness and hypotension, the nurse needs to apply transcutaneous pacing. This client is symptomatic, so that is why this action needs to be done, to restore proper cardiac function. The other options are not correct.

**94.** What is the correct compression-to-ventilation ratio for cardiopulmonary resuscitation (CPR) for an adult?

1. 15:2
2. 15:1
3. 5:2
4. 5:1

(1) 15:2 is the correct compression-to-ventilation ratio for cardiopulmonary resuscitation (CPR) for an adult, not the other options.

**95.** For the client with a suspected neck injury, what is the technique the nurse should use to open the airway?

1. head tilt-chin lift
2. jaw thrust
3. finger sweep
4. Heimlich

(2) The jaw thrust is the technique used to open the airway in the client with a suspected neck injury, in order to avoid further trauma to the neck, not the remaining options.

**96.** Which of the following signs or symptoms is found in the client with an arterial leg ulcer?

1. lower leg edema
2. thick, hardened skin
3. brisk capillary refill
4. absent pedal pulses

(4) Absent pedal pulses are found in the client with an arterial leg ulcer. The remaining options are found in clients with venous leg ulcers.

**97.** A nurse is caring for a client in the immediate postoperative period, who had a right carotid endarterectomy. The right side of the client's neck begins swelling a large amount. What should the nurse do?

1. Monitor the swelling.
2. Check the left side of the neck.
3. Notify the physician.
4. Increase IV fluids.

(3) The physician should be notified immediately for this client, as a large amount of swelling indicates possible post-operative bleeding. Thus, the other responses are not correct.

**98.** A client is receiving heparin therapy for a deep vein thrombosis. Which of the following medications should the nurse be aware of possibly having an adverse effect with the heparin therapy?

1. aspirin (acetylsalicylic acid)
2. Theobid (theophylline)
3. Atenolol (tenormin)
4. Isordil (isosorbide dinitrate)

(1) Aspirin may increase the bleeding time of the patient receiving heparin even more. The other medications do not have such an effect.

**99.** At which area of the abdomen should the nurse palpate the liver?

1. right upper quadrant
2. left upper quadrant
3. right lower quadrant
4. left lower quadrant

(1) The liver is palpated at the right upper quadrant, at the costal margin, not the other options.

**100.** Of which of the following food groups should the most servings be consumed?

1. fats, oils, and sweets
2. milk, yogurt, and cheese
3. bread, cereal, rice, and pasta
4. vegetables

(3) Foods from the bread, cereal, rice, and pasta should be consumed the most. The other foods are eaten in lesser quantities.

**101.** What is the leading cause of maternal death among African American women?

1. ectopic pregnancy
2. toxemia
3. placenta previa
4. abruptio placenta

(1) Ectopic pregnancy is the leading cause of maternal death among African American women. The other causes of maternal death are not as prevalent in this cultural group.

**102.** Which of the following has *not* been linked to the acceleration of menopause?

1. smoking
2. chemotherapy
3. contraceptive use
4. radiation

(3) Contraceptive use has not been linked to the acceleration of menopause. However, the remaining options do have such a linkage.

**103.** A client who has reached menopause says to the nurse, “I feel so sad that I can no longer have babies.” Which of the following is an appropriate response of the nurse?

1. “You should be glad that you don’t have to give birth again.”
2. “At least you don’t have to worry about getting pregnant.”
3. “You can be happy not to have menses anymore.”
4. “Tell me more about why you feel sad about this.”

(4) This is the most appropriate statement, because it allows the client to ventilate her feelings. The other statements are insensitive and may not hold true for the client. Such remarks by the nurse could damage trust with the client.

**104.** Which of the following may be a complication of previous infection with human papilloma virus (HPV)?

1. cervical cancer
2. breast cancer
3. bone cancer
4. skin cancer

(1) Certain types of HPV infection may predispose a woman to developing cervical cancer later in life. The other cancers do not have a direct link to HPV infection.

**105.** Which of the following is a long-term complication of pelvic inflammatory disease (PID)?

1. embolism
2. peritonitis
3. sepsis
4. infertility

(4) Infertility is a long-term complication of pelvic inflammatory disease (PID). The other responses are short-term complications of PID.

**106.** A client with pelvic inflammatory disease (PID) tells the nurse that she feels ashamed of having developed PID from having multiple sexual partners. Which of the following actions by the nurse is most appropriate?

1. leaving the room so that the client can be alone
2. telling the client that she has to abstain from sex
3. consoling the client, and reinforcing client teaching
4. berating the client, and making her feel guilty

(3) This response shows greatest caring by the nurse. Teaching on treatment and prevention of PID will be more effective if the client has trust in the nurse. The other responses are inappropriate. There is no need for the client to be alone. Telling a client that she “has to abstain from sex” will not facilitate trust, nor compliance. It is the client’s choice as to what to do in the situation. Berating the client and making her feel guilty will destroy trust and diminish psychological healing.

**107.** Which of the following is *not* a complication of polycystic ovary syndrome (PCOS)?

1. ovarian cancer
2. malnourishment
3. amenorrhea
4. acne

(2) The client with PCOS does not become malnourished, but rather, may become obese. The remaining options may be found in the client with PCOS.

**108.** A client has been treated for uterine cancer with internal radiation therapy. Which of the following complications may she develop later?

1. cystitis
2. arthritis
3. hepatitis
4. neuritis

(1) A client who has been treated for uterine cancer with internal radiation therapy may later develop cystitis. The other options are not associated with internal radiation therapy.

**109.** In order to prevent age-related changes occurring after menopause, for the client who chooses not to undergo hormone therapy, the nurse should teach the client the most important self-care measure is:

1. perform weight-bearing exercises.
2. perform regular aerobic exercises.
3. drink more milk each day.
4. take vitamin B complex tablets.

(1) This is the most important measure, to avoid bone loss. The other measures are applicable to the menopausal woman, but not as important.

**110.** A client with benign prostatic hypertrophy (BPH) is prone to developing which of the following complications?

1. colitis
2. pulmonary embolus
3. urinary tract infection
4. epididymitis

(3) The client with BPH is prone to developing a urinary tract infection. This is due to the incomplete emptying of the bladder, causing urinary stasis with resulting infection. The other options are not associated with BPH.

**111.** A Native American diagnosed with benign prostatic hypertrophy (BPH) tells the nurse that he would like to take saw palmetto to treat his condition. Which is an appropriate response of the nurse?

1. "Taking an herb is an old-fashioned idea."
2. "Herbs will not work to treat this problem."
3. "You need to take medication, not herbs."
4. "I will notify the physician of your request."

(4) This is the culturally appropriate response. Saw palmetto has been shown to improve urinary flow and symptoms. The physician needs to be notified in order to determine whether there may interaction with any of the other client's medications, and if the physician feels the therapy may benefit this particular client. The other options are not culturally sensitive, and not necessarily accurate. As such, they may damage the nurse-client relationship.

**112.** Which of the following actions by a nurse reduces the complication of blood clot retention after a client has undergone a transurethral resection of the prostate (TURP)?

1. increasing Coumadin dosage
2. maintaining bladder irrigation
3. administering aspirin tablets
4. giving subcutaneous Heparin

(2) Maintaining bladder irrigation will reduce the complication of blood clot retention after a client has undergone a transurethral resection of the prostate (TURP). The other actions do not reduce blood clot retention. In fact, in the immediate postoperative period, such anticoagulants may be contraindicated, since they could cause increased bleeding.

**113.** Which of the following statements by a client who has just had a transurethral resection of the prostate (TURP) indicates adequate understanding of self-care at home, to prevent complications?

1. "I will empty my indwelling catheter bag once a day."
2. "I will drink 1,000 ml of fluid daily."
3. "I will avoid heavy lifting at home."
4. "I will resume intercourse immediately."

(3) The client who has had a TURP should avoid lifting more than 10 lbs. The other statements are not correct, because the indwelling catheter bag should be emptied at least every eight hours. The client should drink 2000–3000 ml of fluid each day. Intercourse will not be resumed right away; usually at least several weeks of abstaining from sexual activity are required.

**114.** Which of the following nursing diagnoses is most appropriate for the client who has just had a transurethral resection of the prostate (TURP)?

1. risk for falls
2. noncompliance
3. diarrhea
4. sexual dysfunction

(4) Sexual dysfunction is the most appropriate diagnosis for the client who has had a TURP, since many clients are impotent after surgery. The other diagnoses do not directly relate to a client who has had a TURP.

**115.** Which of the following statements by a client who has just had a transurethral resection of the prostate (TURP) indicates the need for further teaching by the nurse?

1. "I will drink lots of water to flush my bladder."
2. "I will drink lots of coffee to flush my bladder."
3. "I will refrain from driving for a while."
4. "I will refrain from sexual activity."

(2) Since coffee acts as a bladder irritant, it should be avoided postoperatively to prevent the development of infection. The other statements indicate correct understanding.

**116.** Which of the following statements by a client instructed on testicular self-examination indicates the need for further teaching by the nurse?

1. "I will examine myself after taking a cold shower."
2. "I will use both hands to examine my testes."
3. "I will examine myself the same day each month."
4. I will notify my physician of any abnormalities."

(1) The client should take a warm shower or bath prior to testicular self-exam, as the testes will then hang lower, for easier examination. The other statements indicate correct understanding of testicular self-examination.

**117.** Which of the following papillary changes indicates herniation of the brain?

1. fixed, bilaterally dilated pupils
2. fixed, unilaterally dilated pupil
3. doll's eye phenomena
4. sluggish, equal papillary response

(2) A fixed, unilaterally dilated pupil indicates herniation of the brain. The other options are associated with other brain injury conditions.

**118.** A client lying in which of the following positions exhibits disruption of motor fibers in the brainstem?

1. Trendelenburg
2. opisthotonic
3. decorticate
4. decerebrate

(4) A client lying in the decerebrate position exhibits disruption of motor fibers in the brainstem. In this position, the arms are extended, adducted, and hyperpronated. There is hyperextension of the legs along with plantar flexion. The other positions are not indicative of this problem.

**119.** Which of the following is a major complication of uncontrolled increased intracranial pressure (ICP)?

1. diuresis
2. hemorrhage
3. herniation
4. hypoglycemia

(3) Cerebral herniation is a major complication of uncontrolled increased intracranial pressure (ICP). This occurs when the brain tissue herniates through the opening created by the brainstem, in response to increasing pressure. The other conditions do not relate to increased ICP.

**120.** Which of the following medications may be given to a client with increased intracranial pressure (ICP), in order to minimize vasogenic edema?

1. Pentobarbital (Nembutal)
2. Cimetidine (Tagamet)
3. Dexamethasone (Decadron)
4. Omeprazole (Prilosec)

(3) Decadron may be given to a client with increased intracranial pressure (ICP), in order to minimize vasogenic edema. The other medications are also often given to the client with increased ICP, but for different reasons.

**121.** Which of the following scores on the Glasgow Coma Scale reveals greatest neurologic impairment?

1. 8
2. 10
3. 12
4. 15

(1) A score of 8 on the Glasgow Coma Scale reveals greatest neurologic impairment. Three areas are scored: Eyes Open, Best Verbal Response, and Best Motor Response. The lower the score, the worse the neurologic impairment.

**122.** Which breathing pattern is indicative of metabolic brain dysfunction?

1. apneustic
2. Cheyne-Stokes
3. cluster
4. ataxic

(2) Cheyne-Stokes breathing pattern is indicative of metabolic brain dysfunction. The remaining options describe breathing patterns indicative of other problems in the brain.

**123.** Which signs exhibited by a client indicate to the nurse the enlargement of an acute subdural hematoma?

1. ipsilateral pupil constriction
2. contralateral pupil constriction
3. ipsilateral pupil dilation
4. contralateral pupil dilation

(3) Ipsilateral pupil dilation indicates enlargement of an acute subdural hematoma. This means papillary dilation on the same side of the hematoma. The other options are not indicative of an acute subdural hematoma.

**124.** A child is being discharged from the emergency room after being diagnosed with a concussion following a fall from his bicycle. Which of the following statements by the child's mother indicates a need for further teaching by the nurse?

1. "I will stay with him at all times for 2–3 days."
2. "I will notify the doctor if he starts vomiting."
3. "I will keep him off his bicycle for a several weeks."
4. "If his headache gets worse I will give him more Tylenol."

(4) If a client with head injury gets a worsening headache, the physician should be notified immediately, as it may indicate a complication of the head injury. The other statements indicate adequate understanding.

**125.** Which of the following is *not* a sign or symptom of bacterial meningitis?

1. Kernig sign
2. Battle's sign
3. Brudzinski sign
4. photophobia

(2) The Battle's sign is associated with head trauma, not bacterial meningitis. The remaining options are signs or symptoms of bacterial meningitis.

**126.** Which of the following nursing diagnoses has highest priority for the client who has had a stroke?

1. ineffective airway clearance
2. impaired physical mobility
3. impaired swallowing
4. situational low self-esteem

(1) Ineffective airway clearance has highest priority for the client who has had a stroke. This is because the airway must be maintained in order to support life. The other diagnoses are also appropriate for many stroke clients, but they do not have such high priority.

**127.** Which of the following interventions by the nurse will ensure communication with the aphasic client?

1. speaking in a loud volume
2. presenting several ideas at once
3. increasing environmental stimuli
4. asking "yes" or "no" questions

(4) Asking "yes" or "no" questions makes it easier for the aphasic client to communicate. The nurse should speak in a normal volume. Only one or two ideas should be presented at once, and environmental stimuli should be decreased to avoid confusion.

**128.** Which of the following statements by a client indicates poor self-care for headaches?

1. "I will utilize relaxation techniques."
2. "I will drink more coffee."
3. "I will exercise regularly."
4. "I will get more rest."

(2) Caffeinated drinks, such as coffee, can exacerbate headaches, so they should be avoided. The remaining statements indicate good self-care behaviors.

**129.** Which type of seizure is characterized by a brief staring spell, usually lasting a few seconds?

1. absence
2. grand mal
3. myoclonic
4. partial

(1) An absence seizure is characterized by a brief staring spell, usually lasting a few seconds. The remaining options describe other types of seizure activity.

**130.** An epileptic client has a seizure involving lip smacking and automatisms. What type of seizure has the client experienced?

1. absence
2. grand mal
3. psychomotor
4. tonic-clonic

(3) A seizure involving lip smacking and automatisms is called a psychomotor seizure. Automatisms are repetitive movements that may not be appropriate, such as picking at clothing. The remaining options describe other types of seizure activity.

**131.** An epileptic client has a seizure where his arms and legs suddenly jerk, causing him to fall to the ground. Which type of seizure has this client experienced?

1. myoclonic
2. partial
3. absence
4. psychomotor

(1) A myoclonic seizure is one in which a client's arms and legs suddenly jerk, causing him to fall to the ground. The remaining options describe other types of seizures.

**132.** An epileptic client goes into status epilepticus. Which of the following interventions should a nurse do first?

1. Prevent the client from falling.
2. Administer diazepam (Valium).
3. Ensure a patent airway.
4. Establish IV access.

(3) A client in status epilepticus *first* needs a patent airway, in order to sustain life. The other interventions are also appropriate for such a client, but can be done after the airway is open.



**133.** A client begins having grand mal seizures in bed. The nurse is afraid he will injure himself by banging his arms and legs on the side rails. What is the appropriate action of the nurse?

1. Restrain the client's arms and legs.
2. Establish intravenous access.
3. Remove tight clothing.
4. Add padding to the side rails.

(4) The nurse should pad the side rails in order to prevent injury to the client. The client having a seizure should not be restrained. It is appropriate to establish IV access and remove tight clothing in a client having seizures; however, this will not prevent injury from unpadded side rails.

**134.** Which of the following is *not* a proper principle of handwashing?

1. Wash hands before eating.
2. Wash hands for 5 seconds.
3. Wash hands after sneezing.
4. Wash hands after removing gloves.

(2) Hands should be washed from 10–15 seconds, not just 5 seconds. The remaining options are proper principles of handwashing.

**135.** Which of the following illustrates a proper use of gloving?

1. wearing same gloves between clients
2. using disposable gloves twice
3. touching moist body surface without gloves
4. removing gloves after contamination

(4) This is the only proper use of gloving. Gloves should be changed between clients. Disposable gloves may only be used once. Gloves need to be worn when touching moist body surfaces.

**136.** When a patient has tuberculosis, what is the proper type of transmission-based precaution in which to place the patient?

1. standard precautions
2. contact precautions
3. droplet precautions
4. airborne precautions

(4) The client with tuberculosis needs to be placed on airborne precautions, as TB is spread by small-particle airborne bacteria. The remaining options describe other types of precautions.

**137.** Which of the following foods should a nurse with latex allergy avoid?

1. apples
2. oranges
3. bananas
4. grapefruit

(3) The nurse with a latex allergy should avoid bananas, because they may have cross-sensitivity to the foods of bananas, avocados, kiwi, or chestnuts. The remaining options do not pose such a problem.

**138.** Which of the following is commonly known as the fifth vital sign?

1. oxygen saturation
2. level of pain
3. skin color
4. skin temperature

(2) Pain is now referred to as the fifth vital sign. The remaining options may be collected during an assessment, but are not vital signs.”

**139.** A Jewish client requests separate trays for meat and dairy products. What is the appropriate response of the nurse?

1. Ask the patient why he believes he needs two trays.
2. Tell him a patient can only have one tray.
3. Notify dietary of the need for separate trays.
4. Instruct the patient that only one tray is needed.

(3) This is the culturally sensitive response. A Jewish client may follow Kosher laws and not want meat and dairy products mixed. The remaining options are not culturally sensitive.

**140.** When the nurse is determining the length of insertion for a nasogastric tube, where should her measurements be located?

1. from the tip of the nose to earlobe to xiphoid process
2. from the bridge of the nose to the earlobe to xiphoid process
3. from the earlobe to the sternum to the navel
4. from the mouth to the navel

(1) This is the area where measurements are for determining length of insertion for a nasogastric tube. The remaining options do not encompass the areas traversed by such a tube and, thus, would not provide accurate measurement.

**141.** Which of the following procedures describes a way to assess for proper placement of a nasogastric (NG) tube?

1. determining if the client feels any discomfort
2. checking the client’s oxygen saturation level
3. asking the client whether he is able to swallow
4. injecting air through the NG and listening for sound

(4) This is the accurate way to assess for proper placement of an NG tube. The nurse will hear a rush of air if the NG is properly placed. The other options do not ensure proper NG placement.

**142.** What is the proper position of the patient when receiving a nasogastric (NG) feeding?

1. prone
2. High Fowler’s
3. Trendelenburg
4. side-lying

(2) The client receiving an NG feeding should be placed in High Fowler’s position, with the head of the bed raised 30 to 45 degrees. This is so the client will not accidentally aspirate any of the feeding. The remaining positions put the client at risk for aspiration.

**143.** Which of the following positions should the nurse place a client who is about to have a lumbar puncture performed?

1. prone
2. Sim's
3. supine
4. Trendelenburg

(2) The client should be placed in lateral Sim's position, which will facilitate needle insertion for a lumbar puncture. The remaining positions do not facilitate needle insertion.

**144.** Which of the following positions should the nurse place a client who is about to have a liver biopsy performed?

1. prone
2. supine
3. Sim's
4. Trendelenburg

(2) The client who is about to have a liver biopsy should be positioned on his back, with his right arm above his head. This facilitates needle insertion for a liver biopsy. The remaining positions do not facilitate such needle access.

**145.** When preparing the female's meatus prior to urinary catheterization, how many times should the meatus be cleansed?

1. none
2. one
3. two
4. three

(4) The female's meatus should be cleansed at least 3 times prior to urinary catheterization. This will prevent urinary infection.

**146.** After a urinary retention catheter has been placed in a male, where should tape be placed to hold the catheter into position?

1. abdomen
2. inner thigh
3. outer thigh
4. pubis

(1) A retention catheter in a male should be taped in place on the abdomen, in order to prevent pressure on the peno-scrotal angle. The other areas do not provide such pressure relief.

**147.** After a urinary retention catheter has been placed, where should the urine collection bag be placed?

1. on the side rail
2. on the head board
3. on the bed frame
4. on the floor

(3) The urine collection bag needs to be placed at a level lower than the bladder, on an unmoveable part of the bed, such as the bed frame. The other options are either moveable and/or above the bladder, except the floor. Placement of the bag on the floor can lead to a risk of infection, due to contamination.

**148.** Which position should the penis be held by the nurse for greatest ease of insertion of a urinary catheter?

1. horizontal to the body
2. diagonal to the body
3. lengthwise to the body
4. vertical to the body

(4) The penis should be held in a position vertical to the body, as this straightens the urethra, for ease of insertion. The remaining positions do not straighten the urethra.

**149.** A male client who has continuous bladder irrigation begins to develop bladder spasms. The nurse notices that the urine output is decreasing and is becoming bright red. Which of the following should the nurse do first?

1. Get an order for a complete blood count.
2. Check the catheter for clotting.
3. Increase the rate of the irrigation.
4. Turn off the rate of the irrigation.

(2) The nurse should first check the catheter for clotting. With the urine more bright red, it indicates increased bleeding. The spasms may be caused by a clot blocking the catheter. The irrigation may be turned off while the nurse is checking for a clot, and irrigating it out by hand with an irrigation kit. By relieving the clot, the irrigation can then be increased, to prevent further clotting. The blood count can then be checked, to see whether the CBC has dropped significantly with the bleeding.

**150.** An elderly Iranian woman needs to have a urethral catheterization done. Her male nurse comes to insert the catheter, and she asks that a female nurse to do the procedure. What is the most appropriate response of the male nurse?

1. "I will get one of the women nurses to do this for you."
2. "I can do this procedure as well as the women nurses."
3. "I have done this procedure on women many times."
4. "Don't worry, I know how to catheterize a woman."

(1) This is the most appropriate response, as it shows respect for the client's wishes, as well as cultural sensitivity. Many clients from the Middle East prefer to have those of the same sex perform such intimate procedures. The remaining responses do not show such cultural sensitivity.

**151.** A female catheter has a suprapubic urinary catheter inserted. Where should the catheter tubing be taped?

1. on the inner thigh
2. on the outer thigh
3. on the abdomen
4. on the pubis

(3) The suprapubic catheter should be taped on the female's abdomen. This is because it will cause less irritation to the skin around the catheter exit site, as it will not pull against the skin. The other positions do not afford such prevention of irritation.

**152.** How should the nurse collect a urine specimen from a closed urinary drainage system?

1. Open the drainage spout and empty into container.
2. Disconnect the catheter from the drainage tubing.
3. Discontinue the system and ask the client to void.
4. Access the aspiration port for a specimen.

(4) In order to maintain sterility, the aspiration port should be accessed for a urine specimen. Option 1 would not give a fresh urine specimen, as it would have been in the collection bag for some time. Option 2 poses a risk for infection for the client. Option 4 would not be a collection from the closed system, but from the client, if it were even possible for the client to void.

**153.** A nurse is providing stoma care to a client with a new colostomy. As she is cleaning the site, she notices the color of the stoma. What is a normal finding?

1. red
2. black
3. blue
4. brown

(1) A new colostomy stoma should be a bright red color, indicating healthy circulation. The remaining colors would not indicate healthy tissue.

**154.** Which of the following statements by a client with a ileal conduit indicates a need for further teaching by the nurse?

1. "I will wash my hands after the procedure."
2. "I will empty the bag when it is totally full."
3. "I will be sure to close the drainage port."
4. "I will empty the bag into my toilet."

(2) The urinary drainage bag of an ileal conduit should be emptied when it is half-full, in order to prevent overflow and leakage. The remaining statements indicate adequate understanding of instruction.

**155.** Which of the following statements by a client receiving hemodialysis reveals adequate self-care of an arteriovenous fistula in the right arm?

1. "I will check for a thrill over the site weekly."
2. "I will carry heavy loads with my right arm."
3. "I will take blood pressures in my left arm."
4. "I will have blood drawn from my right arm."

(3) This is the only statement reflecting adequate self-care, since blood pressures and blood draws need to be avoided in the affected arm. Heavy loads should not be carried with the affected arm. The site needs to be checked at least daily for a thrill, because if one is not felt, then the physician needs to be notified immediately.

**156.** Which of the following statements by a client on a bowel-training program indicates adequate self-care?

1. "I will decrease my fluid intake."
2. "I will defecate a different time each day."
3. "I will limit my intake of food with fiber."
4. "I will increase my exercise program."

(4) A bowel-training program includes an increase in exercise, in order to stimulate the abdominal muscles, and to provide overall health and circulation. Fluids and fiber will be increased, and the client is encouraged to defecate at the same time each day in order to provide a pattern for the bowels.

**157.** How long should the nurse instruct a client to hold a tap water enema after instillation?

1. 1–2 minutes
2. 3–5 minutes
3. 6–9 minutes
4. 10–15 minutes

(4) For maximal effectiveness, an enema should be held from 10–15 minutes after instillation. Less time will not allow for movement and action of the instilled fluid to occur.

**158.** What is the maximum amount of enema solution that should be instilled at one time in an adult?

1. 100 cc
2. 500 cc
3. 1,000 cc
4. 1,500 cc

(3) The maximum amount of enema solution that should be instilled into an adult is 1000 cc. The remaining options are either not enough, or too much.

**159.** Which position should the nurse place the client in for receiving an enema?

1. prone
2. left lateral
3. right lateral
4. supine

(2) The client receiving an enema should be placed in left lateral position. This is because the descending colon is located on the left side, and placing the client on the left side will facilitate effectiveness of the fluid instillation. The other positions do not provide for such effect.

**160.** A client has received Dermabond to close a wound on his arm. Which of the following instructions should the nurse give the client?

1. “The Dermabond will slough off in about a week.”
2. “The doctor will need to remove the Dermabond.”
3. “The Dermabond will absorb into your body.”
4. “I can remove the Dermabond in two days.”

(1) Dermabond will slough off in 7 to 10 days. It is important for the nurse to know this, as it is being used more frequently. The other statements are not correct.

**161.** A client has a one inch reddened area to the sacrum. The skin is intact. What stage of pressure ulcer does this client have?

1. Stage I
2. Stage II
3. Stage III
4. Stage IV

(1) A reddened area to the skin, with no opening in the skin, is a Stage I pressure ulcer. The remaining options are more advanced stages of pressure ulcers.

**162.** Which type of treatment procedure is indicated for a Stage I pressure ulcer?

1. chemical debridement
2. surgical intervention
3. normal saline irrigation
4. adhesive film dressing

(4) A Stage I pressure ulcer requires an adhesive film dressing to be applied by the nurse. The remaining options are treatments for more advanced stages of pressure ulcers.

**163.** Which type of treatment procedure is indicated for a Stage IV pressure ulcer?

1. chemical debridement
2. surgical intervention
3. normal saline irrigation
4. adhesive film dressing

(2) Surgical intervention is required for a Stage IV pressure ulcer. The remaining options are procedures required for less advanced pressure ulcers.

**164.** A client has a 2-inch diameter ulcer on his hip, extending through the subcutaneous tissue. What stage of pressure ulcer does this client have?

1. Stage I
2. Stage II
3. Stage III
4. Stage IV

(3) An ulcer that goes through the subcutaneous tissue is a Stage III ulcer. The remaining options describe other stages of pressure ulcers.

**165.** A client has a 2-cm ulcer on his left heel, which goes through all the tissues, down to the bone. What stage of pressure ulcer does this client have?

1. Stage I
2. Stage II
3. Stage III
4. Stage IV

(4) An ulcer that goes down to the bone is a Stage IV pressure ulcer. The remaining options describe other stages of pressure ulcers.

**166.** Which of the following interventions will prevent formation of pressure ulcers?

1. Use harsh cleansing agents.
2. Massage bony prominences.
3. Use elbow pads and heel protectors.
4. Bathe client using hot water.

(3) This is the only way of the above options to prevent formation of pressure ulcers. Mild cleansing agents should be used, to prevent dryness of the skin. Bony prominences should not be massaged, as it can lead to tissue trauma. Tepid water is used for bathing, to prevent injury to skin.





# Physiological Adaptation

This chapter contains questions and answers from the following topic areas:

- Alterations in Body Systems
- Fluid and Electrolyte Imbalances
- Hemodynamics
- Illness Management
- Infectious Diseases
- Medical Emergencies
- Pathophysiology
- Radiation Therapy
- Unexpected Response to Therapies

**1.** One of the *most* important pulmonary treatments in cystic fibrosis is:

1. inhaled beta agonists.
2. inhaled corticosteroids.
3. chest physiotherapy.
4. oral enzymes.

(3) The major pulmonary problem with CF is thick tenacious secretions. CPT moves the secretions from the small airways to the large where they can be coughed out. Options 1 and 2 are used but are secondary to option 3; the oral enzymes that CF patients take are for digestion, not pulmonary reasons.

**2.** Percussion of a pleural effusion will produce:

1. resonance.
2. hyperresonance.
3. hyporesonance.
4. dullness.

(4) Fluid will produce dull sounds; resonance is heard over normal lungs; hyperresonance is heard when excess air is in the chest, as in pneumothorax or emphysema; hyporesonance is not a percussion sound.

**3.** In a patient with a new central venous line, the RN notes shortness of breath and ipsilateral absent breath sounds. What diagnostic exam will most likely be ordered?

1. arterial blood gases
2. chest x-ray
3. pulmonary function tests
4. ventilation-perfusion scan

(2) Pneumothorax is a common complication of CVL insertion, and CXR will confirm the diagnosis suggested by the assessment (SOB and absent BS). Option 1 is a generic test to look for ventilation and oxygenation problems. Option 3 is to differentiate obstructive from restrictive disease. Option 4 is to look for pulmonary embolus, which doesn't fit history or assessment.

- 4.** A patient with asthma calls the RN at a family practice clinic stating that today's peak expiratory flow is 70 percent of personal best. The RN suspects:
1. pneumonia.
  2. mild exacerbation of asthma.
  3. moderate exacerbation of asthma.
  4. severe exacerbation of asthma.

(3) 60–80 percent PEF = mod. exacerbation; option 1 would have fever and sputum changes; option 2 PEF would be 80 percent or better; for option 4, PEF would be less than 50 percent.

- 5.** A patient is awaiting results from a fiberoptic bronchoscopy with brushings and washings. The most appropriate nursing diagnosis appropriate for this patient is:
1. anxiety related to possibility of cancer diagnosis.
  2. pain related to biopsy.
  3. impaired verbal communication related to endotracheal tube.
  4. body image disturbance related to possible cancer diagnosis.

(1) Bronchoscopy is commonly done to diagnose lung cancer; the majority of patients do not report significant pain after bronchoscopy; endotracheal intubation is not a routine step in bronchoscopy; option 4 is not likely at this point, as most patients will not suffer body image disturbance until after the diagnosis is actually made, if then.

- 6.** A patient is in the ER after a car crash demonstrating paradoxical chest wall motion. A chest x-ray shows fractures of ribs 2–6. The RN will expect the patient to be treated with:
1. oxygen therapy and observation.
  2. continuous positive airway pressure by mask.
  3. mechanical ventilation with PEEP.
  4. immediate tracheotomy.

(3) A flail chest is treated with PEEP to splint the fractured ribs from the inside; options 1 and 2 are not aggressive enough, as the paradoxical motion from multiple contiguous fractured ribs (flail segment) will quickly wear the patient out; option 4 would be used for an obstructed airway, possibly for severe facial fractures.

- 7.** The RN is caring for a patient with a chest tube after a right upper lobectomy. On the day of surgery, the RN notes bubbling in the water-seal chamber. What is this, and what should the RN do?
1. air leak, expected finding
  2. air leak, notify physician
  3. suction control, expected finding
  4. suction control, decrease wall suction

(1) Until the lung incision seals, there will be air leaking from it, which will be collected and drained by the chest tube; option 2 would be correct if the air leak had stopped and later reappeared; the suction control chamber is separate from the water seal chamber in a typical chest drainage device.

- 8.** The RN is assessing a patient with pneumonia. Bronchial breath sounds are heard in the posterior lung fields. This represents:
1. atelectasis.
  2. pneumothorax.
  3. consolidation.
  4. normal breath sounds.

(3) Bronchial breath sounds are normally heard only over the trachea and main-stem bronchi; option 1 will demonstrate diminished breath sounds; option 2 will have absent breath sounds on the affected side; option 4 should hear vesicular breath sounds in the posterior fields.

**9.** The RN has finished teaching a patient about treatment of GERD. The RN knows the patient has understood the teaching if she states:

1. "I should eat a small bedtime snack each night."
2. "I should lie flat in bed."
3. "I can have red wine with dinner."
4. "I should eat six small meals daily."

(4) Smaller more frequent meals help decrease reflux. The patient shouldn't eat within 3 hours of bedtime; her head should be elevated—either put bed up on 6-inch blocks or use a wedge; alcohol is contraindicated—it relaxes the GE sphincter and increases reflux.

**10.** The RN is assessing a patient being worked up for anemia. The RN notes distension and mild abdominal tenderness, and the patient states he's been having dark red stools for the past two days. The nurse suspects:

1. upper GI bleed.
2. lower GI bleed.
3. pancreatitis.
4. appendicitis.

(2) Usually dark red stools are from lower GI bleed; the blood is not in the gut long enough to turn black. Upper GI bleed usually demonstrates vomiting if brisk or black stools (melena) if slow; with pancreatitis and appendicitis, the patient will have tenderness, possible distention, but no blood in the GI tract.

**11.** The nurse is caring for a 73-year-old patient with chronic pain being treated with opioids. One complication to be monitored for is:

1. constipation.
2. diarrhea.
3. anorexia.
4. heartburn.

(1) Opioids slow transit through the GI tract; older patients and those being treated chronically are at increased risk. Opioids slow not speed transit through the GI tract; patients with chronic pain often lack appetite from their pain and will eat better when it is relieved; nausea, not heartburn is often seen in the upper GI tract with opioid usage.

**12.** A patient presents to the emergency department with a 12-hour history of intractable vomiting, abdominal distention, and hyperactive bowel sounds. The most important intervention will be:

1. administer an anti-emetic.
2. insert a nasogastric tube.
3. perform a complete nursing history and physical.
4. administer an anti-flatulent.

(2) This patient is demonstrating sign and symptoms of a small bowel obstruction. The NG tube will help decompress the bowel and relieve the vomiting by emptying the stomach. Option 1 won't help with SBO; there is often no nausea in this type of scenario. only vomiting caused by GI contents "backing up." Option 3 is not the priority consideration; the patient will be much better able to give a history after the major symptoms are relieved. The distention is from GI contents being unable to move downstream, not excess gas.

**13.** The treatment for duodenal ulcers includes:

1. bland, soft diet.
2. frequent small meals.
3. antacids.
4. specific antibiotics.

(4) The majority of duodenal ulcers are due to infection with *Helicobacter pylori* and specific antibiotics are the cure. Options 1–3 may make symptoms better, but option 4 is the definitive treatment.

**14.** When teaching a diabetic patient being treated for gastroparesis, the nurse will teach the patient to expect improvement of which symptoms?

1. blood sugar control
2. constipation
3. abdominal cramping
4. peripheral neuropathy

(1) Gastroparesis is the delayed emptying of food from the stomach due to nerve damage. The unpredictable absorption of nutrients makes blood sugar control difficult. Patients often complain of heartburn, early satiety, bloating, and nausea, but not constipation or pain. Treatment of gastroparesis focuses on the stomach rather than the nerves; the treatment won't help other damaged nerves (for example, the feet).

**15.** Preparing a patient for a colonoscopy will likely include:

1. three day fast.
2. high-fat meal.
3. laxatives and enemas.
4. bulk forming laxatives.

(3) In order to perform a colonoscopy, the colon must be completely empty. This may be done with a regimen of laxatives and enemas or a commercial preparation (GoLYTELY). Fasting alone won't get the colon empty; some bowel preparations include fasting or clear liquids, usually for no more than two days. High-fat meal may be given in preparation for gall bladder scanning. Bulk forming laxatives won't get the colon empty, if laxatives are used, they will be of the stimulant or osmotic type.

**16.** Appropriate goals for a nursing diagnosis of constipation related to diverticulitis would include that the patient will:

1. maintain passage of soft formed stool every 1–3 days.
2. maintain passage of soft formed stool once weekly.
3. return demonstration of a soap suds enema.
4. return demonstration of Credé's maneuver.

(1) Soft stools at least every 1–3 days is the expected outcome when constipation is relieved. A stool once a week is still constipated; option 3 is not used to chronically manage constipation. Bulk forming laxatives might be used; Credé's maneuver is used to manage neurogenic bladder.

**17.** When caring for a patient with an enlarged prostate and suspected urinary tract infection, the most important assessment for the RN to make is:

1. frequency of urination.
2. past 24 hours fluid intake.
3. daily weights.
4. post void residual.

(4) An enlarged prostate can cause incomplete emptying of the bladder, setting the patient up for a UTI. Option 1 could be a symptom of UTI, but with prostate enlargement should focus on option 4; options 2 and 3 are more of a concern with renal failure (which can result from long-term untreated obstruction) but hasn't been diagnosed in this patient.

**18.** The RN is caring for a patient whose blood pressure has dropped to 88/47 (baseline BP 137/88). Urine output has been 80 cc over the past 4 hours. Intervention will focus on:

1. diuretics.
2. hemo-dialysis.
3. supporting BP.
4. insert a foley catheter.

(3) This is prerenal failure, that is, the problem with urine output is inadequate cardiac output, and intervention will be directed at increasing BP (fluids, pressors, and so on). Diuretics are used in early intra-renal failure to improve renal function and increase urine output. Hemo-dialysis is used to treat intra-renal failure, that is dysfunction within the kidney itself. A foley catheter is used in post-renal (obstructive) failure, often only intervention needed.

**19.** A patient has been having colicky flank pain and vomiting for 2 days. An intravenous pyelogram demonstrates nephrolithiasis, and the patient is started on gentamycin. After the stone passes, the most likely complication that the nurse will monitor for is:

1. renal failure.
2. bladder obstruction.
3. allergic reaction.
4. increased urine output.

(1) This patient has several risk factors: dehydration from vomiting, obstruction from a stone, treatment with an aminoglycoside (nephrotoxic) and ionic contrast for the IVP (also nephrotoxic). Bladder outlet is larger than the ureters; if the stone managed to get that far downstream, it should be able to be voided. Option 3 is a risk, but this patient is at particular risk for renal failure; option 4 is an expected outcome (favorable), post obstruction diuresis.

**20.** An appropriate nursing diagnosis for a patient after a radical cystectomy and ileal conduit would be:

1. fluid volume deficit.
2. fluid volume overload.
3. alteration in body image.
4. knowledge deficit, self-catheterization.

(3) With an ileal conduit, the patient has a stoma and wears a collection bag. Options 1 and 2 are not a particular risk for this patient. The conduit runs all the time, there is no need to catheterize.

**21.** A patient on chronic hemodialysis is hospitalized with pulmonary edema related to dietary indiscretion. The RN will reinforce proper renal diet as follows:

1. low potassium, high protein, fluid restricted
2. high potassium, high protein, fluid restricted
3. low sodium, moderate protein, fluid restricted
4. low sodium, low protein, moderate fluid

(3) Sodium stimulates thirst; the patient needs enough protein to prevent muscle wasting, but not so much as to produce excessive nitrogenous wastes (BUN); fluids must be restricted to prevent fluid overload between dialysis treatments. Low potassium and fluids are correct; protein should be limited to 1–1.5 g/kg/day; potassium and protein must be limited. The patient must take in enough protein to prevent wasting and decreased albumin levels; fluids must be limited.

**22.** The most common complication of patients on peritoneal dialysis is:

1. volume overload.
2. dehydration.
3. elevated blood sugar.
4. infection.

(4) Specifically peritonitis, usually due to poor aseptic technique. Options 1–3 all can occur but are far less common.

**23.** When administering intravenous electrolyte solution, the nurse should take which of the following precautions?

1. Infuse hypertonic solutions rapidly.
2. Mix no more than 80 mEq of potassium per liter of fluid.
3. Prevent infiltration of calcium, which will cause tissue necrosis and sloughing.
4. As appropriate, re-evaluate the patient's digitalis dosage; he or she may need an increased dosage since IV calcium diminishes digitalis' action.

(3) Preventing tissue infiltration is necessary to avoid skin damage. Hypertonic solutions should be infused cautiously. Potassium should be mixed at a concentration no higher than 60 mEq/L. Calcium (particularly intravenous)

**24.** Teaching about the need to avoid foods high in potassium would be most important for which patient?

1. a patient receiving diuretic therapy
2. a patient with an ileostomy
3. a patient with metabolic alkalosis
4. a patient with renal disease

(4) Patients with renal disease are predisposed to hyperkalemia and, thus, should avoid foods high in potassium. Patients receiving diuretics, with ileostomies, or with metabolic alkalosis all may be hypokalemic and, thus, should be encouraged to eat foods high in potassium.

**25.** What do the following ABG values—pH, 7.38; PO<sub>2</sub>, 78 mmHg; PCO<sub>2</sub>, 36mmHg; HCO<sub>3</sub>, 24 mEq/L—indicate?

1. metabolic alkalosis
2. homeostasis
3. respiratory acidosis
4. respiratory alkalosis

(2) These ABG values are within normal limits. These ABG values indicate none of the acid-base disturbances in options 1, 3, and 4.

**26.** The major electrolytes in the extracellular fluid are:

1. potassium and chloride.
2. potassium and phosphate.
3. sodium and choride.
4. solium and phosphate.

(3) Sodium and chloride are the major electrolytes in the extracellular fluid.

**27.** Which physiologic mechanism best describes the function of the sodium-potassium pump?

1. active transport
2. diffusion
3. filtration
4. osmosis

(1) Active transport is a process requiring energy to transport ions against a concentration gradient, as is needed in the sodium-potassium pump. Diffusion, filtration, and osmosis are other regulatory mechanisms involved in fluid and electrolyte balance.

**28.** Laboratory tests reveal the following electrolyte values for Mr. Smith. Na, 135 mEq/L; Ca, 8.5 mg/dL; Cl, 102 mEq/L; K, 2.0 mEq/L. Which of these values should the nurse report to the physician because of its potential risk to the patient?

1. Ca
2. K
3. Na
4. Cl

(2) Normal serum potassium level ranges between 3.5 and 5.5 mEq/L. These, Na, Ca, and Cl levels are within normal ranges.

**29.** A patient receiving drug therapy with furosemide (Lasix) and digitalis requires careful observation and care. In planning care for this patient, the nurse should recognize that one of the following electrolyte imbalances would be most likely to occur, requiring nursing intervention. Which one?

1. hyperkalemia
2. hyponatremia
3. hypokalemia
4. hypomagnesemia

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

**30.** The statement that best describes electrolytes in intracellular and extracellular fluid is that there is:

1. a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
2. equal concentration of sodium and potassium in extracellular fluid.
3. greater concentration of potassium in extracellular fluid and sodium in intracellular fluid.
4. equal concentration of sodium and potassium between intracellular and extracellular fluid.

(1) There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.

**31.** A nurse is caring for a client with an elevated urine osmolarity. The nurse should assess the client for:

1. fluid volume excess.
2. hyperkalemia.
3. hypercalcemia.
4. fluid volume deficit.

(4) For a client with an elevated urine osmolarity, the nurse should assess the client for fluid volume deficit.

**32.** A physician orders a serum creatinine for a hospitalized client. The nurse should explain to the client and his family that this test:

1. is normal if the level is 4.0–5.5 mg/dL.
2. can be elevated with increased protein intake.
3. is a better indicator of renal function than the BUN.
4. reflects the fluid volume status of a person.

(3) A serum creatinine level should be 0.7–1.5 mg/dL, and it does not vary with increased protein intake; thus, it is a better indicator of renal function than the BUN.

**33.** One of the major functions of the kidneys in maintaining normal fluid balance is:

1. manufacturing of antidiuretic hormone.
2. regulating calcium and phosphate balance.
3. regulating the pH of the extracellular fluid.
4. controlling the levels of aldosterone.

(3) Major functions of the kidneys in maintaining normal fluid balance include regulation of extracellular fluid and osmolality by selective retention and excretion of fluids, regulation of pH of the extracellular fluid by retention of hydrogen ions, and excretion of metabolic wastes and toxic substances. ADH is manufactured by the pituitary, and the parathyroid regulates calcium and phosphate balance.

**34.** A nurse is caring for a client with an elevated cortisol level. The nurse anticipates that the client will exhibit symptoms of:

1. urinary excess.
2. hyperpituitarism.
3. urinary deficit.
4. hyperthyroidism.

(3) High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.

**35.** A nurse is caring for a 66-year-old client diagnosed with renal insufficiency. The nurse should monitor the client for symptoms of:

1. fluid volume excess.
2. fluid volume deficit.
3. potassium excess.
4. sodium excess.

(2) Clients diagnosed with renal insufficiency can exhibit symptoms of hyperkalemia and fluid volume deficit.

**36.** A nurse is caring for a hospitalized adult client who has a serum sodium level of 145 mEq/L and a serum potassium level of 4.0 mEq/L. The nurse should monitor this client for signs of:

1. thirst.
2. fatigue.
3. nausea.
4. anorexia.

(1) The client is experiencing hypernatremia. Signs of this condition include thirst, flushed skin, dry tongue, and increased muscle tone. Fatigue, nausea, and anorexia are symptoms of hyperkalemia; however, this client's potassium level is within a normal range.

**37.** A nurse is caring for a client who is taking diuretic medications. The nurse should instruct the client to eat foods that are high in potassium such as:

1. frozen yogurt.
2. bananas.
3. figs.
4. peanuts.

(2) Foods that are high in potassium include raisins, fruits such as bananas and oranges, milk, whole grains, and meat.



**38.** A nurse is caring for a client who is hospitalized and diagnosed with Addison's disease. The nurse should monitor the client for symptoms of:

1. hypocalcemia.
2. hypernatremia.
3. hypokalemia.
4. hyperkalemia.

(4) A client with Addison's disease is at risk for hyperkalemia because this condition is characterized by deficient adrenal hormones, leading to sodium loss and potassium retention.

**39.** A nurse is caring for a hospitalized adult client with a serum magnesium level of 1.3 mEq/L and a serum phosphorus level of 4.2 mEq/L. The nurse should monitor the client for symptoms of:

1. athetoid movements.
2. facial flushing.
3. dysarthria.
4. drowsiness.

(1) A serum magnesium level of 1.3 mEq/L is indicative of hypomagnesemia. The nurse should monitor the client for athetoid movements, tetany, and muscle weakness. Facial flushing, dysarthria, and drowsiness are symptoms of hypermagnesemia.

**40.** A client is hospitalized with a diagnosis of chronic hepatic insufficiency and has a  $\text{PaCO}_2$  level of 35 mmHg. The nurse determines that this client is most likely experiencing:

1. respiratory acidosis.
2. respiratory alkalosis.
3. metabolic acidosis.
4. metabolic alkalosis.

(2) A client with a  $\text{PaCO}_2$  level of 35 mmHg is experiencing respiratory alkalosis, since the  $\text{PaCO}_2$  level is below 40 mmHg.

**41.** G.R. complains of nausea, vomiting, and abdominal distention. These are probably related to:

1. hyponatremia.
2. hypernatremia.
3. hyperkalemia.
4. hypokalemia.

(4) Hypokalemia—loss of potassium from the body; shift of potassium from the extracellular fluid to the intracellular fluid; it is one of the most common electrolyte imbalances; the patient may report anorexia, nausea and vomiting, drowsiness, lethargy, constipation, leg cramps, abdominal distention.

**42.** You advised G.R. to eat foods rich in potassium. You would recommend all of the following foods high in potassium except:

1. dry fruits.
2. bananas, prunes.
3. broccoli, peanut butter.
4. egg, whole-grain breads.

(4) The nurse should instruct the client to include potassium-rich foods, such as kidney beans, orange juice, carrots, broccoli, bananas, prunes, and dry fruits in the diet.

**43.** G.R. asks why she has to take potassium. The best response would include the following except:

1. “Your diuretic causes not only water and sodium to be excreted but also potassium.”
2. “Your serum potassium level is low, and Slow K helps to prevent a potassium deficit.”
3. “Your healthcare provider should discontinue the potassium supplement after a week.”
4. “The potassium supplement should maintain a normal potassium level in your body while you are taking the diuretic (potassium-wasting diuretic).”

(3) Treatment focuses on restoring normal potassium balance, preventing serious complications, and removing or treating the underlying causes of hypokalemia. Serum potassium levels should be monitored carefully. If potassium supplement is given, monitor the serum potassium levels; discontinue potassium when appropriate lab and clinical findings are within normal limits.

**44.** Which of the following serum potassium levels would indicate hyperkalemia?

1. 5.9 mEq/L
2. 4.6 mEq/L
3. 3.8 mEq/L
4. 2.9 mEq/L

(1) Hyperkalemia occurs when the serum potassium level rises above 5 mEq/Liter. The normal level is very narrow (3.5 to 5mEq/Liter), a slight increase can have profound consequences as cardiac arrest, smooth muscle hyperactivity, and particularly the GI tract.

**45.** Which of the following diseases or conditions is least likely to be associated with increased potential for bleeding?

1. metastatic liver cancer
2. gram-negative septicemia
3. pernicious anemia
4. iron deficiency anemia

(3) Pernicious anemia results from vitamin B<sub>12</sub> deficiency due to lack of intrinsic factor; this can result from inadequate dietary intake, faulty absorption from GI tract due to lack of secretion of intrinsic factor normally produced by gastric mucosal cells, and certain disorders of the small intestine that impair absorption. The nurse instructs the client in the need for life-long replacement of vitamin B<sub>12</sub>; folic acid, rest, diet, and support.

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

1. increased platelet count
2. increased fibrinogen
3. decreased fibrin split products
4. decreased bleeding

(2) Effective heparin therapy should stop the process of intravascular coagulation, which should result in increased fibrinogen; Heparin administration, which interferes with thrombin-induced of fibrinogen to fibrin; bleeding should cease due to the increased availability of platelets and coagulation factors; DIC always occurs secondary to an underlying disease or condition, including: septicemia, obstetrical complications, disseminated malignancies, massive tissue injury (burns and trauma), hemolytic transfusion reaction, shock, and anaphylaxis.

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

1. cushingoid appearance
2. alopecia
3. temporary or permanent sterility
4. pathologic fractures

(4) Pathologic fractures are not common to the disease process or its treatment, although osteoporosis may be potential complication of steroid use; Hodgkin's disease most commonly affects young adults (males) and is spread through lymphatic channels to contiguous nodes. It also may spread via hematogenous route to extradal sites (GI, bone marrow, skin, and other organs); a working "staging" classification is done for clinical use and care.

**48.** Which of the following would be an inappropriate item to include in planning care for a severely neutropenic patient?

1. Transfuse netrophils (granulocytes) to prevent infection.
2. Exclude raw vegetables from the diet.
3. Avoid administering rectal suppositories.
4. Prohibit vases of fresh flowers and plants in the patient's room.

(1) Granulocyte transfusion is not indicated to prevent infection; produced in the bone marrow, granulocytes normally compromise 70 percent of all WBCs. They are subdivided into three types based on staining properties: neutrophils, eosinophils, and basophils. They may be beneficial in selected population of infected, severely granulocytopenic patients (less than  $500/\text{mm}^3$ ) not responding to antibiotic therapy and who are expected to experience prolonged suppressed granulocyte production.

**49.** Patients who take iron preparations should be warned of the possible side effects, which may include:

1. dizziness and orthostatic hypotension.
2. nausea, vomiting, diarrhea, and stomach cramps.
3. drowsiness, lethargy, and fatigue.
4. neuropathy and tingling in the extremities.

(2) Oral iron preparations are often used to help those patients who have iron deficiency anemia to regain a positive iron balance; these preparations need to be supplemented with adequate dietary intake of iron. It can take 2–3 weeks to see improvement and up to 6–10 months to return to a stable iron level once a deficiency exists; the most common adverse effects associated with oral iron are related to direct GI upset, anorexia, nausea, vomiting, diarrhea, dark stools, and constipation.

**50.** What happens if folic acid is given to treat anemias without determining the underlying cause of the anemia?

1. Erythropoiesis is inhibited.
2. Excessive levels of folic acid may accumulate, causing toxicity.
3. The symptoms of pernicious anemia may be masked, delaying treatment.
4. Intrinsic factor is destroyed.

(3) Folate deficiencies usually occur secondary to increased as a result of absorption problems in the small intestine; usually given with vitamin  $B_{12}$ ; they are both essential for cell growth and division and for the production of a strong stroma in the RBCs. Folic acid is used as a rescue drug for cells exposed to some toxic chemotherapeutic agents; confirm the nature of the anemia to ensure that the proper drug regimen is being used.

**51.** Which of the following would not be included in the teaching for a patient who take oral iron preparations?

1. Mix the liquid iron preparation with antacids to reduce GI distress.
2. Take the iron with meals if GI distress occurs.
3. Liquid forms should be taken with a straw to avoid discoloration of tooth enamel.
4. Oral forms should be taken with juice not milk.

(1) Iron is a toxic substance if too much is taken; iron can be taken with food, orange juice, and never with eggs, milk, coffee, and tea.

**52.** The test used to differentiate sickle cell anemia/sickle cell trait is:

1. sickle cell preparation.
2. peripheral smear.
3. sickledex.
4. hemoglobin electrophoresis.

(4) Hemoglobin electrophoresis is used for the confirmation and discrimination between anemia/trait (sickle cell trait—HbS and HbA; sickle cell anemia—HbS); a test to identify various abnormal hemoglobins in the blood, including certain genetic disorders, as sickle cell anemias.

**53.** The anemias most often associated with pregnancy are:

1. folic acid and iron deficiency.
2. folic acid deficiency and Thalassemia.
3. iron deficiency and Thalassemia.
4. Thalassemia and B<sub>12</sub> deficiency.

(1) Folic acid and iron deficiency anemia is one of the most common anemias, prevalent in women of childbearing age with 50 percent of pregnant women having this type of anemia. Iron deficiency anemia during pregnancy is a result (usually) of the increase in the plasma level during pregnancy but not in the constituent level. Also, if a woman has this type of anemia prepregnancy, it will get worse during pregnancy.

**54.** Neural tube defects in the fetus have been primarily associated with which deficiency in the mother?

1. iron
2. folic Acid
3. vitamin B<sub>12</sub>
4. vitamin E

(2) Neural Tube Defect—any of a group of congenital malformations involving defects in the skull and spinal column that are caused primarily by the failure of the neural tube to close during embryonic development. Folic acid is essential for the development of the neural tube and prevent the defect or failure of the tube to close (congenital anomalies).

**55.** Elderly persons with pernicious anemia should:

1. be instructed to increase their dietary intake of foods high in B<sub>12</sub>.
2. be told they will not need to return for follow-up for at least a month after initiation of treatment.
3. be told that oral B<sub>12</sub> is safer and less expensive than parenteral replacement.
4. be told that diarrhea can be a transient side effect of B<sub>12</sub> injections.

(4) Pernicious anemia—a megaloblastic, macrocytic, normochronic anemia caused by a deficiency of the intrinsic factor produced by the stomach, which results in malabsorption of vitamin B<sub>12</sub> necessary for DNA synthesis and maturation of RBC. Education should include side effects of vitamin B<sub>12</sub>: pain and burning at injection site, peripheral vascular thrombosis, and transient diarrhea; comfort/safety measures.

**56.** Which of the following would be included in a diet rich in iron?

1. peaches, eggs, beef
2. cereals, kale, cheese
3. red beans, enriched breads, squash
4. legumes, green beans, eggs

(1) Home sources of iron include meat, poultry, and fish that can be absorbed in the body; in addition these sources contain a factor that helps to enhance iron absorption of nonheme sources as well as the diet. Eating vitamin C at the same time with iron sources in the diet also helps to promote iron absorption; high calcium intake in the diet promotes the absorption of iron, because it helps to bind to phytates and thereby limits their effect; and the use of iron-containing cookware can increase the iron content in the diet.

**57.** In alcoholics with anemia:

1. pernicious anemia is more common than folic acid deficiency.
2. iron deficiency, folic acid deficiency may coexist.
3. the alcohol interferes with iron absorption.
4. oral vitamin replacement is contraindicated.

(2) Due to the ingestion of nonfood substances (alcohol) that leads to a clinical iron deficiency and may actually be the first sign of a problem; the client will substitute alcohol for a nutrition program that fosters a positive health habit.

**58.** A female client complains to the nurse at the Health Department that she has fatigue, shortness of breath, and light-headedness. Her history reveals no significant medical problems. She states that she is always on a “fad” diet without any vitamin supplements. Which tests should the nurse expect for the client to have first?

1. peptic ulcer studies
2. complete blood count, including hematocrit and hemoglobin
3. genetic testing
4. hemoglobin electrophoresis

(2) The beginning tests to determine what the basis of her symptoms and considering her “fad” dieting, should be a complete blood count, urinalysis, blood sugar and others; depending upon the results of these laboratory tests as with history and other factors; the decision on further testing will then be made.

**59.** What is Pica?

1. dependency on alcohol
2. increased iron in the diet
3. sickle cell trait
4. eating of ice

(4) Pica represents the ingestion of nonfood substances that leads to a clinical iron deficiency and may actually be the first sign of a problem; the client will eat a wide range of nonfood items, including ice, clay, dirt, and paste.

**60.** What dietary factors would lead to increased absorption of iron in the client’s digestive tract?

1. nonheme sources
2. ascorbic acid
3. oxalic acid
4. vitamin D

(2) In order to maximize absorption of iron, meat, fish, and poultry, and ascorbic acid (vitamin C) can be used. Heme iron is considered to be the most absorbable for of iron in the body.

**61.** Indications for folic acid include all of the following except:

1. megaloblastic anemia.
2. tropical sprue.
3. prophylaxis of fetal neural tube defects.
4. pernicious anemia.

(4) Pernicious anemia is caused by a deficiency of intrinsic factor produced by the stomach, which results in malabsorption of vitamin B<sub>12</sub>, necessary for DNA synthesis and maturation of RBC.

**62.** Which of the following actions would the nurse expect to perform after a patient has a bone marrow biopsy taken from the iliac crest?

1. Apply pressure to the site for one minute.
2. Administer a narcotic analgesic.
3. Apply an adhesive bandage to the site.
4. Place the patient in a recumbent position.

(4) The patient should lie in bed in a recumbent position on top of a pressure dressing that has been applied to the site. Hemorrhage poses a slight risk after this procedure. Pressure should be applied to the site for several minutes. A pressure dressing should then be applied for one hour to reduce the chances of bleeding or hemorrhage; an analgesic may be ordered and administered prior to the procedure. Use of deep-breathing techniques may also be helpful. There is some pain after the biopsy, although the site may ache for a few days. Bone marrow produces blood cells, platelets, granulocytes, and some types of immune reactive cells, including lymphocytes and macrophages.

**63.** A patient with anemia is to receive 1 unit of packed red blood cells. The nurse will plan to administer the unit over which period of time?

1. 30 minutes–1 hour
2. 2–3 hours
3. 4–5 hours
4. 1–2 hours

(2) The unit of packed cells should be infused over a period of 2–3 hours. If it is infused over a shorter period, there is greater chance of circulatory overload. The blood should run very slowly at 2 ml per minute during the first 15 minutes; the duration of administration of a blood transfusion should not exceed 4 hours. Anemia due to blood loss can be sudden, due to trauma, or slow, due to peptic ulcer or bleeding from intestines; Anemia is a decrease in number of erythrocytes with an abnormally low hemoglobin level, resulting in decreased oxygen to cells.

**64.** Miriam Roth, a patient with acute myelogenous leukemia (AML), had an allogeneic bone marrow transplant three days ago. To monitor Ms. Roth for development of graft-versus-host disease (GVHD), the nurse will watch for:

1. a temperature change > 101°F.
2. development of a skin rash.
3. bleeding from the gums.
4. crackles in the lungs.

(2) A skin rash is usually the first sign of GVHD. Most tissues can be attacked by the disease, but the most common sites of symptoms are the skin, GI tract, and liver; a patient who has received a bone marrow transplant is at risk for developing an infection until the donor marrow has been accepted (usually within about 10 days). Taking the temperature and listening to the lungs would be done to monitor the patient for infection.

**65.** The assessment data for a female patient with anorexia nervosa include: hemoglobin 6.0 g/dL; weight 70 lb; height 5'9"; dyspnea on ambulation; and pale skin and mucous membranes. Based on this information, which of the following nursing diagnoses would have the highest priority in the nurse's care plan?

1. high risk for impaired skin integrity related to decreased tissue perfusion
2. knowledge deficit related to dietary iron deficiency
3. activity intolerance related to dyspnea and weakness
4. altered nutrition, less than body requirements, related to anorexia

(4) Anorexia nervosa is a severe eating disorder in which very limited amounts of food and nutrients are consumed. Anorexia nervosa is an indirect self-destructive behavior. Among many other complications, anorexia results in anemia, as indicated in the assessment data. Inadequate intake of iron, vitamin B<sub>12</sub>, and folic acid leads to anemia, decreased hemoglobin levels lead to decreased oxygenation of the body tissues. If adequate nutrients are taken in and absorbed by the body through diet or supplementation, the anemia and its symptoms should improve; thus, altered nutrition is the highest priority diagnosis.

**66.** Teaching the client with gonorrhea how to prevent reinfection and further spread is an example of:

1. primary prevention.
2. secondary prevention.
3. tertiary prevention.
4. primary health care prevention.

(2) Secondary prevention—targets the reduction of disease prevalence and disease morbidity through early diagnosis and treatment.

**67.** The following immunizations are very important for the individual (adult and children) to have as preventable diseases. The nurse in teaching the client should emphasize the importance of getting the following vaccines:

1. human papillomavirus, genital herpes, measles.
2. pneumonia, HIV, mumps.
3. syphilis, gonorrhea, pneumonia.
4. smallpox, pertussis, measles.

(4) Vaccines are one of the most effective methods of preventing and controlling communicable diseases. The smallpox vaccine, which left distinctive scars on so many shoulders, is no longer in use, because the smallpox virus has been declared eradicated from the world's population. Diseases such as polio, diphtheria, pertussis, and measles, which previously occurred in epidemic proportions, are now controlled by routine childhood immunization. They have not, however, been eradicated, so children need to be immunized against these diseases; nurses are in a key position particularly at health departments to educate adults and children to the necessity of getting immunized against diseases.

**68.** Acyclovir is the drug of choice for:

1. HIV.
2. HSV 1 and 2 and VZV.
3. CMV.
4. influenza A viruses.

(2) Acyclovir (Zovirax) is specific for herpes virus infections. It is excreted unchanged in the urine and, therefore, must be used cautiously in the presence of renal impairment; drugs that combat herpes inhibit viral DNA replication by competing with viral substrates to form shorter, noneffective DNA chains.

**69.** Tuberculosis (Mycobacterium) usually effects which system?

1. stomach (GI)
2. heart (cardiac)
3. lungs (respiratory)
4. skin (integumentary)

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

**70.** Which of the following statements is true about syphilis?

1. The cause and mode of transmission is unclear.
2. There is no known cure of the disease.
3. When the primary lesion heals, the disease is cured.
4. Syphilis can be cured with a course of antibiotic therapy.

(4) Syphilis is an acute and chronic treponemal disease characterized clinically by a primary lesion, a secondary eruption involving skin and mucous membranes, long periods of latency, and late lesions of skin, bone viscera, the CNS and cardiovascular system. The primary lesion (chancre) appears about three weeks after exposure as an indurated, painless ulcer with a serous exudate at the site of initial invasion. Invasion of the bloodstream precedes the initial lesion, and a firm, nonfluctuant, painless lymph node (bubo) commonly follows.

Infection may occur without a clinically evident chancre; for example, it may be in the rectum or on the cervix. After 4–6 weeks, even without specific treatment, the chancre begins to involute and, in approximately one-third of untreated cases, a generalized secondary eruption appears, often accompanied by mild constitutional symptoms. This symmetrical maculopopular rash involving the palms and soles, with associated lymphadenopathy is classic. Secondary manifestations resolve spontaneously within weeks to 12 months; again, about one-third of untreated cases of secondary syphilis will become clinically latent for weeks to years. In the early years of latency, there may be recurrence of infectious lesions of the skins and mucous membranes.

Specific treatment: long-acting penicillin G (benzathine penicillin), 2.4 million units given in a single IM dose on the day that primary, secondary or early latent syphilis is diagnosed; this assures effective therapy even if the patient fails to return.

Serologic testing is important to ensure adequate therapy; tests are repeated at 3 and 6 months after treatment and later as needed. In HIV infected patients, testing should be repeated at 1, 2, and 3 months, and at 3-month intervals thereafter. Any fourfold titer rise indicates the need for retreatment.

**71.** The sexually transmitted disease sometimes referred to as the silent STD, which is more common than gonorrhea and a leading cause of PID, is:

1. genital herpes.
2. trichomoniasis.
3. syphilis.
4. chlamydia.

(4) Chlamydia is a sexually transmitted genital infection and is manifested in males primarily as a urethritis and in females as a mucopurulent cervicitis. Clinical manifestations of urethritis are often difficult to distinguish from gonorrhea and include mucopurulent discharges of scanty or moderate quantity, urethral itching, and burning on urination. Asymptomatic infection may be found in 1 to 25 percent of sexually active men. Possible complications or sequelae of male urethral infections include epididymitis, infertility, and Reiter syndrome. In homosexual men, receptive anorectal intercourse may result in chlamydial proctitis.

In the female, the clinical manifestations may be similar to those of gonorrhea and frequently present as a mucopurulent endocervical discharge, with edema, erythema and easily induced endocervical bleeding caused by inflammation of



the endocervical columnar epithelium. However, up to 70 percent of sexually active women with chlamydial infections are asymptomatic. Complications and sequelae include salpingitis with subsequent risk of infertility, ectopic pregnancy, or chronic pelvic pain. Asymptomatic chronic infections of the endometrium and fallopian tubes may lead to the same outcome.

**72.** Which of the following is true concerning human immunodeficiency virus (HIV)?

1. HIV infection involves CD4 receptor protein on the surface of helper T-cells.
2. The presence of circulating antibodies that neutralize HIV is evidence that the individual has immunity HIV.
3. HIV replication occurs extracellularly.
4. DNA replication is similar to that of other viruses.

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

**73.** Which of the following viruses is most likely to be acquired through casual contact with an infected individual?

1. influenza virus
2. herpes virus
3. cytomegalovirus (CMV)
4. human immunodeficiency virus (HIV)

(1) Influenza virus is transmitted through respiratory droplets. Herpes virus is transmitted by direct contact and HIV through blood and body fluids. Cytomegalovirus is an opportunistic infection.

**74.** A female prostitute enters the clinic for treatment of a sexually transmitted disease. Given that this disease is the most prevalent in the United States, the nurse can anticipate that the woman has which of the following?

1. herpes
2. chlamydia
3. gonorrhea
4. syphilis

(2) Epidemiological studies indicate chlamydia as the most prevalent sexually transmitted disease in the United States.

**75.** Nurses should understand the chain of infection because it refers to:

1. the linkages between various forms of microorganisms.
2. the sequence required for transmission of disease.
3. the clustering of bacteria in a specific pattern.
4. increasing virulence patterns among species of microorganisms.

(2) Infection occurs in a predictable sequence requiring virulence, movement from a reservoir, and entry into a susceptible host.

**76.** Which of the following microorganisms is easily transmitted from patient to patient on the hands of healthcare workers?

1. mycobacterium tuberculosis
2. clostridium tetani
3. staphylococcus aureus
4. human immunodeficiency virus

(3) Staphylococcus aureus microorganisms are ubiquitous and easily transmitted by healthcare workers who fail to conduct routine handwashing between patients; tuberculosis is almost always transmitted by the airborne route, and tetanus usually results from exposure to dirt. HIV is a weak virus that does not live long outside the body.

**77.** In order to demonstrate immunity to measles, mumps, and rubella, a person is required to provide which of the following forms of evidence?

1. having been born before 1945
2. documented administration of one dose of vaccine
3. written report by mother of nurse describing childhood infection with the diseases
4. laboratory evidence of immunity

(4) All people who work in healthcare should demonstrate evidence of immunity to measles, mumps, and rubella by one of the following: having been born before 1957, documented administration of two doses of vaccine, laboratory evidence of immunity, or documentation of physician-diagnosed measles or mumps.

**78.** The Centers for Disease Control and Prevention (CDC) are primarily responsible for:

1. reporting and tracking disease outbreaks and environmental hazards.
2. educating the public.
3. reducing the public's risk exposure.
4. treating infected individuals.

(1) The CDC's goals are to provide scientific recommendations regarding disease prevention and control in order to reduce disease. The Occupational Safety and Health Administration's goal is to reduce the public's risk exposure.

**79.** The goal of the Occupational Safety and Health Administration is to:

1. report and track disease outbreaks and environmental hazards.
2. educate the public.
3. reduce the public's risk exposure.
4. treat infected individuals.

(3) The Occupational Safety and Health Administration's goal is to reduce the public's risk exposure. The CDC's goals are to provide scientific recommendations regarding disease prevention and control in order to reduce disease.

**80.** The patient who has been diagnosed with shingles asks for the name of the childhood disease that is caused by the same microorganism as shingles. The nurse responds that the disease is:

1. measles.
2. rubella.
3. smallpox.
4. chickenpox.

(4) Varicella zoster is the causative viral agent of chickenpox and herpes zoster, shingles.

**81.** Which of the following statements about the trends of HIV infection is accurate?

1. The number of heterosexual women with AIDS is increasing at a faster rate than in homosexual men.
2. The rate of infection in Caucasian women is higher than in African-American or Hispanic women.
3. AIDS is more prevalent in rural residents than in urban residents.
4. The number of pediatric cases of AIDS is remaining stable.

(1) AIDS is a severe disease syndrome that was first recognized in 1981. This syndrome represents the late clinical stage of infection with the human immunodeficiency virus (HIV). Within several weeks to several months after infection with HIV many persons develop an acute self limited mononucleosis-like illness lasting for a week or two. Infected persons may then be free of clinical signs or symptoms for many months or years before other clinical manifestations develop. The severity of subsequent HIV related opportunistic infections or cancers is, in general, directly correlated with the degree of immune system dysfunction. More than a dozen opportunistic infections and several cancers were

considered to be sufficiently specific indicators of the underlying immunodeficiency for inclusion in the initial case definition of AIDS developed by CDC in 1982. These diseases, if diagnosed by standard histologic and/or culture techniques, were accepted as meeting the surveillance definition of AIDS developed by CDC, if other known causes of immunodeficiency had been ruled out.

**82.** When an individual has AIDS, the HIV destroys the body's immune system primarily by:

1. infecting the vital organs.
2. infecting helper T cells.
3. infecting B lymphocytes.
4. infecting red blood cells.

(2) Serologic tests for antibodies to HIV have been available commercially since 1985. The most commonly used screening test (EIA or ELISA) is highly sensitive and specific. However, when this test is reactive, it must be supplemented by an additional test, such as the Western blot or indirect fluorescent antibody (IFA) test. A nonreactive supplemental test negates the initial reactive EIA test; a positive reaction supports it, and an indeterminate result in the Western blot test calls for further evaluation. WHO recommends as an alternative to the routine use of Western blots and the IFA, the use of another EIA test that is methodologically and/or antigenically independent of the initial EIA tests. Because of the extreme personal significance of a positive HIV antibody test, it is recommended that an initial positive test be confirmed with a second specimen from the patient so as to eliminate possibilities of mislabeling and transcription errors.

**83.** The nurse discovers a sputum sample at a patient's bedside. The sample is dated with today's date, along with the patient's name and identification number, but there is no time marked on it. What should the nurse do in this situation?

1. Send the sample to the clinical laboratory immediately.
2. Discard the sample and collect another one as soon as possible.
3. Send the sample to the clinical laboratory immediately but call the laboratory to tell them that the collection time is unknown.
4. Refrigerate the sample and call the clinical laboratory to pick up the specimen as soon as possible.

(2) Prompt delivery and analysis of microbiologic specimens is essential. Because the specimen had set for an unknown period, it must be discarded. The actions in options 1, 3, and 4 would be inappropriate; another sample must be obtained.

**84.** Because of the impact of STD transmission on relationships, the nurse must proceed carefully when assessing a person with suspected STD, covering all the following topics *except*:

1. previous history of STDs.
2. names of sexual partners.
3. presence of dysuria.
4. sexual history.

(2) It is inappropriate to ask for names in the assessment phase. Should the patient be found to have an STD, instruct the person to notify sex partners and encourage them to be assessed and treated, if necessary. Sexual history and previous STD history is important information to assess the current and future risk of contracting STDs. Dysuria is a common symptom of STDs.

**85.** When planning care for a patient in a healthcare facility, the nurse must be aware that a nosocomial infection:

1. occurs only in immunocompromised hosts.
2. occurs in at least 30 percent of patients in a given hospital.
3. usually is present within a community but is not always clinically apparent.
4. is acquired in a health care facility.

(4) Nosocomial infections are hospital acquired, which means that exposure to the causative organism occurred while a person was hospitalized. Nosocomial infections are not present or incubating on admission to the hospital. A hospital is one of the most likely places to acquire an infection. Microorganisms that may be antibiotic resistant and more virulent than microorganisms normally found in the community are present in the hospital environment. Hospital-acquired infections affect more than 2 million patients each year in the United States or approximately 6 percent of all people admitted to acute care facilities. Surgical patients have the highest incidence of infection. Nearly 70 percent of all nosocomial infections develop in postoperative patients. Factors that predispose individuals to acquiring a nosocomial infection include extremes of age, compromised body defenses, exposure to invasive procedures, and long-term hospitalization. The major sites affected by nosocomial infections are the urinary tract, surgical wounds, respiratory system, and the bloodstream.

**86.** All of the following interventions are recommended to prevent nosocomial wound infections *except*:

1. avoiding hair removal when possible.
2. changing dressings on closed wounds only when they become wet or if signs of infection occur.
3. if hair removal is necessary, using a clean, sharp-edged razor.
4. maintaining asepsis during surgery by limiting personnel movement in and out of the OR.

(3) If hair removal is necessary, depilatories or clippers are suggested. Avoiding hair removal except when absolutely necessary, changing dressing only when necessary, and maintaining asepsis are all appropriate interventions.

**87.** When the patient informs the nurse that he is experiencing hypoglycemia, the nurse provides immediate treatment by providing:

1. one commercially prepared glucose tablet.
2. two hard candies.
3. 4–6 ounces of fruit juice with one teaspoon of sugar added.
4. 2–3 teaspoons of honey.

(3) The usual recommendation for treatment of hypoglycemia is for 10–15 grams of a fast-acting simple carbohydrate, orally, such as 3 or 4 commercially prepared glucose tablets or 4–6 ounces of fruit juice or soda. It is not necessary to add sugar to juice, even if it is labeled as unsweetened juice, because the fruit sugar in juice contains enough simple carbohydrate to raise the blood glucose level, and additional of sugar may result in a sharp rise in blood sugar that will last for several hours.

**88.** Which of the following injuries, if demonstrated by the patient entering the Emergency Room, would take highest priority?

1. open leg fracture
2. open head injury
3. stabbing to the chest
4. traumatic amputation of thumb

(3) Only a few conditions, such as obstructed airway or a sucking chest wound, take precedence of control of hemorrhage. Stabbing to the chest generally results in a sucking chest wound that can result in lung collapse and mediastinal shift causing death.

**89.** Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of the patient who has experienced trauma?

1. The clothing is property of another and must be treated with care.
2. Such care will facilitate repair and salvage of the clothing.
3. The clothing of the trauma victim is potential evidence with legal implications.
4. Such care will decrease trauma to the family members receiving the clothing.

(3) Trauma in any patient, living or dead, has potential legal, or forensic implications. Clothing itself, as well as patterns of stains, debris, and so on, are sources of potential evidence and must be preserved. Nurses must be aware of state and

local regulations that require mandatory reporting of cases of suspected child and elder abuse, accidental deaths, and suicides. Each ER has written policies and procedures to assist nurses and other healthcare providers in making appropriate reports. Physical evidence is real, tangible, or latent matter that can be visualized, measured, or analyzed. ER nurses are often called on to collect evidence, and all hospitals should have policies governing the collection of forensic evidence. It is of utmost importance that the chain of custody be followed to ensure the integrity and credibility of the evidence. The chain of custody is the pathway that evidence follows from the time it is collected until it has served its purpose in the legal investigation of an incident.

**90.** Which of the following terms refers to soft tissue injury caused by blunt force?

1. contusion
2. strain
3. sprain
4. dislocation

(1) A contusion is a soft tissue injury caused by blunt force. It is an injury that does not break the skin, caused by a blow to the body, and characterized by a swelling, discoloration, and pain. The immediate applications of cold may limit the development of a contusion. A strain is a muscle-pull from overuse, overstretching or excessive stress. A sprain is caused by wrenching or twisting motion. A dislocation is a condition in which the articular surfaces of the bones forming a joint are no longer in anatomic contact.

**91.** The nurse teaches the patient in the emergency room, who has suffered an ankle sprain to:

1. use cold applications to the sprain during the first 24–48 hours.
2. expect disability to decrease within first 24 hours of injury.
3. expect pain to decrease within 3 hours after injury.
4. begin progressive passive and active range of motion exercises immediately.

(1) Cold applications are believed to produce vasoconstriction and reduce edema. The disability and pain are anticipated to increase during the first 2–3 hours after injury. Progressive passive and active exercises may begin in 2–5 days, according to the doctor's recommendation. A sprain is a traumatic injury to the tendons, muscles, or ligaments around a joint, characterized by pain swelling and discoloration of the skin over the joint. The duration and severity of the symptoms vary with the extent of damage to the supporting tissues. Treatment requires support, rest, and alternating cold and heat. X-ray pictures are often indicated to be certain that no fracture has occurred.

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

1. anemia
2. edema
3. painless vaginal bleeding
4. fatigue

(3) Placenta Previa is a disorder where the placenta implants in the lower uterine segment, causing painless bleeding in the third trimester of pregnancy; the bleeding results from tearing of the placental villi from the uterine wall as the lower uterine segment contracts and dilates. It can be slight or profuse; bright red, painless bleeding, abdomen soft, nontender, and relaxes between contractions.

**93.** When caring for a patient with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?

1. perineal shave
2. enema
3. urine specimen collection
4. blood specimen collection

(2) An enema could dislodge the placenta and increase bleeding.

**94.** Melissa Smith came to the emergency room in the last week before her estimated date of confinement complaining of headaches, blurred vision, and vomiting. Suspecting advanced PIH, the nurse would best respond to Mary's complaints with which of the following statements?

1. "The doctor probably will want to admit you for observation."
2. "The doctor probably will order bed rest at home."
3. "These are really dangerous signs."
4. "The doctor will prescribe some medicine for you."

(2) PIH is Pregnancy Induced Hypertension and is a hypertensive disorder of pregnancy, developing after 20 weeks' gestation and characterized by edema, hypertension, and proteinuria (preclampsia and eclampsia). The cause is unknown. The patient with advanced PIH needs rest, and home is the best place to get it. Hospitalization would not be necessary in this situation. Medication is not indicated.

**95.** Which of the following blood pressure parameters indicates PIH? Elevation over baseline of:

1. 30 mmHg systolic and/or 15 mmHg diastolic.
2. 40 mmHg systolic and/or 20 mmHg diastolic.
3. 10 mmHg systolic and/or 5 mmHg diastolic.
4. 20 mmHg systolic and/or 20 mmHg diastolic.

(1) These are the accepted parameters for mild PIH. Mild preclampsia includes an increase in systolic blood pressure, 30 mmHg or increase in diastolic blood pressure, 15 mmHg above baseline, noted on two readings taken six hours apart, or 140/90.

**96.** When discussing possible complications of pregnancy with a patient, the nurse would explain that all of the following are symptoms of urinary tract infection during pregnancy *except*:

1. low back pain.
2. urinary frequency.
3. GI distress.
4. malaise.

(2) Urinary frequency is common minor discomfort of pregnancy and is caused by pressure of the growing uterus on the bladder. As the uterus rises as in the second trimester, there are no problems, frequency returns in the third trimester when the uterus "drops" into the pelvic cavity. A Urinary Tract Infection (UTI) has the symptoms of frequency, back pain, supra pubic discomfort, malaise and is diagnosed by laboratory findings.

**97.** When assessing a patient in the emergency room whose membranes have ruptured, the nurse notes that the fluid is a greenish color. What is the cause of this greenish coloration?

1. blood
2. meconium
3. hydramnios
4. caput

(2) Greenish amniotic fluid passed by a fetus in a cephalic (head) presentation may indicate fetal distress. A fetus in the breech presentation will pass meconium due to compression on the intestinal tract.

**98.** With a breech presentation, the nurse must be particularly alert for which of the following?

1. quickening
2. ophthalmia neonatorum
3. pica
4. prolapsed umbilical cord

(4) Prolapsed umbilical cord is the descent of the umbilical cord into the vagina before the fetal presenting part and compression of the cord between the presenting part and the maternal pelvis, compromising or completely cutting off fetoplacental perfusion. This is an emergency situation, immediate delivery will be attempted to save the fetus. Frequently seen in breech presentations when there is a space between the presenting part and the cervix through which the cord compresses.

**99.** In the emergency room, the client has a fetus in vertex presentation, membranes have just ruptured, and there is possible fetal distress. What nursing intervention should receive the highest priority?

1. Assess FHR.
2. Call the physician.
3. Assess maternal vital signs.
4. Assess maternal emotional status.

(1) The fetal heart rate (FHR) should be assessed immediately following ruptured membranes, IV fluids started; notations of time; color of fluid, fetal status should be recorded; vital signs, admit to labor and delivery.

**100.** Which of the following nursing interventions would *not* be appropriate for a patient just admitted with vaginal bleeding in the third trimester of pregnancy?

1. careful admission history
2. specific assessment of amount of bleeding
3. vaginal examination to determine progress of cervical dilation
4. vital signs every 15 minutes

(3) Vaginal examination should not be performed when a client presents with vaginal bleeding in the third trimester as this could cause more bleeding due to possible puncture or tearing of the placenta or damage to fetal blood vessels.

**101.** The prognosis for fetal survival following abruption placentae is less than 50 percent. For infants who survive, there is a high degree of morbidity. Knowing this, nursing intervention should focus on which of the following?

1. monitoring maternal physiologic status
2. monitoring maternal and infant physiologic status
3. providing emotional support regarding the imminent delivery of a deceased or defective baby
4. administering tocolytic agents to arrest labor

(2) Both mother and baby should be monitored carefully to promote survival and to decrease risk of morbidity. Abruptio placenta is the premature separation of a normally implanted placenta during the last half of pregnancy, often with severe internal or external bleeding. Assessment findings of serious nature, possibly loss of FHR, pain, severe shock, renal failure, DIC (disseminated intravascular conglutination), maternal/fetal death.

**102.** Cold stress is harmful to a newborn because of which of the following outcomes?

1. peripheral vasodilation
2. alkalosis
3. decreased metabolic activity
4. acidosis

(4) Cold stress constricts pulmonary vessels and decreases blood flow, causing hypoxia and an increase in ketone bodies. It also increases metabolic rate and, with hypoxia, causes anaerobic glycolysis and metabolic acidosis.

**103.** Nonshivering thermogenesis is a means of increasing body temperature through:

1. increased muscle activity.
2. metabolism of subcutaneous fat.
3. increased metabolic activity.
4. metabolism of brown fat.

(4) Cold stress stimulates the sympathetic nervous system to release norepinephrine, which causes the metabolism of brown fat.

**104.** The nurse's first responsibility in the management of postpartum hemorrhage is to do which of the following?

1. Notify the physician prior to taking any action.
2. Massage the uterus firmly until it remains hard.
3. Take the woman's vital signs.
4. Call for blood type and cross-match and have IV equipment ready.

(2) The primary cause of postpartum hemorrhage is uterine atony. Fundal massage promotes the contraction of the uterus. Uterine massage is the initial recommended intervention.

**105.** The highest priority for the nurse in caring for a client that has had a car accident and has just been brought into the emergency room is:

1. immediate assessment of ABC.
2. hunt for a room for this client.
3. avoid worsening any injuries that have been caused by the car accident.
4. immediately notifying the police department.

(1) The immediate assessment of ABC (Airway, Breathing, and Circulation) is the highest priority in this situation. If the client is having difficulty with a clear airway or breathing problems, this assessment is first.

**106.** Which of the following would likely be a major nursing diagnosis for a person in the hypodynamic phase of septic shock requiring prompt intervention?

1. ineffective individual coping
2. altered patterns of urinary elimination
3. decreased cardiac output
4. high risk for infection

(3) Although ineffective coping may occur, especially in earlier stages of septicemia, the hypodynamic phase represents a grave situation, one in which the patient may be obtunded or comatose. The septicemia may have begun as a urinary tract infection, but at the hypodynamic stage, the UTI is not likely to be a major problem. Oliguria is the probable alteration in urinary elimination. Although the septic patient is a risk for potential additional infections, the major problem is the sequelae from the existing infections. The diagnoses in options 1, 2, and 4, although possibly pertinent, would not likely be as high a priority as decreased cardiac output for the patient.



**107.** A patient with septicemia is at risk for coagulation defects. Thus, one goal of nursing intervention is to minimize the patient's blood loss. Specific indicators of successful attainment of this goal would include all of the following except:

1. the patient displays blood pressure of 130/78 mmHG.
2. the patient exhibits a hematocrit level of 37.
3. the patient exhibits CVP of 8 cm H<sub>2</sub>O.
4. the patient demonstrates a heart rate of 135 beats per minute.

(4) Tachycardia may result from blood loss with a resultant increase in heart rate to maintain cardiac output. Septicemia is a systemic infection in which pathogens are present in the circulating blood stream, having spread from an infection in any part of the body. It is diagnosed by culture of blood and is vigorously treated by antibiotics; characteristically, septicemia cause chills, fever, prostration, pain, headache, nausea, or diarrhea. It is a condition of the blood caused by virulent microorganisms ("blood poisoning"). Options 1, 2, and 3 all are normal values, indicating stable cardiovascular and hematologic status.

**108.** Shock is most accurately defined as a/an:

1. decreased circulating blood volume.
2. inability of the heart to pump blood.
3. inadequate oxygen supply to vital organs.
4. hemorrhage as a result of trauma.

(3) Shock is a life-threatening condition with a variety of underlying causes. The term, shock, is best defined as an inadequate supply of oxygen to vital organs through the systemic blood pressure; an abnormal condition of inadequate blood flow to the body's peripheral tissues, and oliguria; the condition is usually associated with inadequate cardiac output, changes in peripheral blood flow resistance and distribution, and tissue damage.

**109.** Which of the following is an example of an autoimmune disease?

1. tuberculosis
2. hypertension
3. hemophilia
4. scleroderma

(4) Scleroderma is an autoimmune disease, not the other options.

**110.** Which of the following medications may be given to a client who has just received a heart transplant, to prevent organ rejection?

1. Levodopa (Dopar)
2. Cyclosporine (Neoral)
3. Lorazepam (Ativan)
4. Probenecid (Benemid)

(2) Cyclosporine is an immunosuppressive medication, not the other options.

**111.** A client with human immunodeficiency disease (HIV) receives antiretroviral medication in order to:

1. treat pneumocystic carinii.
2. cure the HIV infection.
3. decrease viral load.
4. treat Kaposi's sarcoma.

(3) Antiretroviral medications decrease viral load, not the other options.

**112.** A nurse has just discovered that her client is HIV positive. Which of the following is an appropriate response?

1. refusing to care for the client
2. telling other staff to avoid the client
3. putting the client in respiratory isolation
4. observing universal precautions

(4) The nurse should use universal precautions for HIV positive clients, as well as all clients. The nurse has an ethical duty to care for the client and cannot tell other staff to avoid the client. Respiratory isolation is not necessary.

**113.** Which mnemonic is used to remember the seven warning signs of cancer?

1. CAUTION
2. DANGERS
3. WARNING
4. CANCERS

(1) C: Change in bowel or bladder habits; A: A sore that does not heal; U: Unusual bleeding or discharge from any body orifice; T: Thickening or a lump in the breast or elsewhere; I: Indigestion or difficulty swallowing; O: Obvious change in a wart or mole; N: Nagging cough or hoarseness. The other options are not mnemonics relating to cancer.

**114.** Cancer is characterized by which of the following cell changes?

1. rapid proliferation
2. toxin production
3. increased differentiation
4. indiscriminate proliferation

(4) Cancer cells are characterized by indiscriminate proliferation, not the other options.

**115.** A client has a cancerous tumor on his tibia. What name is given this type of tumor?

1. adenoma
2. osteoma
3. fibroma
4. meningioma

(2) An osteoma is a tumor on bone tissue. The other options are other types of tumors.

**116.** Which of the following statements by an elderly client indicates correct understanding of presbyopia?

1. "I have astigmatism."
2. "I have blindness."
3. "I am farsighted."
4. "I am nearsighted."

(3) Presbyopia is farsightedness. The other responses refer to other types of refractive disorders.

**117.** Which of the following terms describes the transparent mucous membrane that lines the inner surface of the eyelids?

1. cornea
2. sclera
3. retina
4. conjunctiva

(4) The conjunctiva is the transparent mucous membrane that lines the inner surface of the eyelids. The other options refer to different eye structures.

**118.** Which of the following is an abnormal finding of an otoscopic examination?

1. pearl gray tympanic membrane
2. white tympanic membrane
3. red tympanic membrane
4. pink tympanic membrane

(3) A red tympanic membrane is an abnormal finding of an otoscopic examination, indicating inflammation and/or infection. The other options are normal findings.

**119.** A 65 Kg patient has a 50 percent total body surface area (TBSA) burn. Using 4 ml/kg/% TBSA during the first 12 hours after burn injury, the nurse would use a fluid replacement volume of:

1. 2,500 ml.
2. 3,250 ml.
3. 10,000 ml.
4. 13,000 ml.

(4)  $4\text{ml} \times 65\text{ kg} \times 50\% = 13,000$ .

**120.** A client with a full-thickness burn to the leg with resulting ischemia may undergo what procedure to restore circulation to the area?

1. escharotomy
2. skin graft
3. laparotomy
4. debridement

(1) An escharotomy is used to restore circulation to a full-thickness area of burn, not the other procedures.

**121.** An 18-year-old female client with full-thickness burns to her face says to the nurse, "No man will ever want to date me." Which is a therapeutic response of the nurse?

1. "You are better off concentrating on your schoolwork."
2. "Tell me more about your concerns."
3. "Don't worry, we can fix everything with surgery."
4. "You'll look good as new in no time."

(2) This statement allows the client to ventilate her concerns. The other statements are not empathetic and may instill false reassurances.

**122.** Which of the following adventitious breath sounds may be most indicative of asthma?

1. wheezes
2. coarse crackles
3. fine crackles
4. pleural friction rub

(1) Wheezes are most indicative of asthma. The other adventitious sounds are heard in other conditions.

**123.** The nurse can best assess for tactile fremitus using her:

1. stethoscope.
2. fingertips.
3. palms.
4. otoscope.

(3) Tactile fremitus is assessed using the nurse's palms, not the other options.

**124.** Which of the following nursing diagnoses is most appropriate for a client with an inflated cuffed tracheostomy tube in place?

1. activity intolerance
2. impaired verbal communication
3. ineffective tissue perfusion
4. dysreflexia

(2) Impaired verbal communication is most appropriate, as a cuffed tracheostomy tube does not allow for speech.

**125.** Which of the following is the best term to describe the type of pneumonia that results when a client has inhaled secretions into the lower airway?

1. aspiration pneumonia
2. fungal pneumonia
3. viral pneumonia
4. community-acquired pneumonia

(1) Aspiration pneumonia most specifically refers to when a client has inhaled secretions into the lower airway, not the other options.

**126.** Which of the following terms refers to blood accumulation in the pleural space?

1. pneumothorax
2. hemothorax
3. flail chest
4. chylothorax

(2) Hemothorax refers to blood accumulation in the pleural space. The other terms describe different pulmonary injuries.

**127.** A client who has an enlarged right ventricle due to a pulmonary disease has what disorder?

1. bronchitis
2. pneumonia
3. pericarditis
4. cor pulmonale

(4) Cor pulmonale refers to a disorder resulting in an enlarged right ventricle due to a pulmonary disease, not the other options.

**128.** An elderly client on home oxygen says to his home care nurse, "I feel so lonely stuck here at home on this oxygen." What is the most therapeutic response of the nurse?

1. "Let us discuss ways that you can get out with portable oxygen."
2. "Well, that's what happens when you smoke for 20 years."
3. "Why would someone your age want to go outside?"
4. "You'll just need to make the best of your situation."

(1) This response shows the most caring and critical thinking to solve the client's problem. The other statements are insensitive and do not involve problem-solving.

**129.** Sickle cell disease is most prevalent in which cultural group?

1. Native American
2. African American
3. Asian
4. Hispanic

(2) African Americans have the highest prevalence of sickle cell disease, not the other groups.

**130.** Blood flows from the right ventricle directly to which structure?

1. superior vena cava
2. right atrium
3. pulmonary artery
4. pulmonary vein

(3) Blood flows from the right ventricle directly to the pulmonary artery, not the other cardiac structures listed.

**131.** Which term describes relaxation of the cardiac chambers, allowing them to fill with blood?

1. systole
2. diastole
3. afterload
4. cardiac output

(2) Diastole describes relaxation of the cardiac chambers, allowing them to fill with blood. The remaining terms describe other cardiac activities.

**132.** Which of the following medications functions to decrease cardiac afterload?

1. Rosiglitazone (Avandia)
2. Flumazenil (Romazicon)
3. Fluorouracil (Adrucil)
4. Metoprolol (Lopressor)

(4) Metoprolol (Lopressor), which is a beta-adrenergic blocker, functions to decrease cardiac afterload. The remaining medications have other functions.

**133.** If a client has a blood pressure of 130/80, what is the client's pulse pressure?

1. 20
2. 25
3. 40
4. 50

(4) The pulse pressure is the difference between the systolic and diastolic pressures:  $130 - 80 = 50$ .

**134.** What is the mean arterial pressure (MAP) for a client with a blood pressure of 120/60?

1. 40
2. 60
3. 80
4. 100

(3) The mean arterial pressure = diastolic blood pressure +  $\frac{1}{3}$  pulse pressure. Pulse pressure = systolic BP – diastolic BP = 60. MAP = 60 + 20 = 80.

**135.** In a healthy client, where is the apical pulse auscultated?

1. 5th intercostal space at the midclavicular line
2. 2nd intercostal space to the right of the sternum
3. 2nd intercostal space to the left of the sternum
4. 3rd intercostal space to the left of the sternum

(1) The apical pulse is auscultated at the 5th intercostal space at the midclavicular line. The other options refer to spaces to auscultate other heart sounds.

**136.** A client with mitral valve regurgitation has impaired blood flow between the:

1. right atrium and right ventricle.
2. left atrium and left ventricle.
3. right ventricle and pulmonary vein.
4. left ventricle and pulmonary artery.

(2) A client with mitral valve regurgitation has impaired blood flow between the left atrium and left ventricle. The remaining structures have other valves between them.

**137.** Which of the following statements by a client who has just received teaching regarding risk factors for coronary artery disease indicates a need for additional instruction?

1. "I will eat more red meat."
2. "I will begin an exercise program."
3. "I will start using relaxation techniques."
4. "I will stop smoking cigarettes."

(1) Red meat contains fats, which can increase the risk of coronary artery disease. The other options are ways to decrease such risk.

**138.** Which of the following medications will assist a client who is being treated for a myocardial infarction, to relieve associated constipation from bed rest and narcotic administration?

1. Sotalol (Betapace)
2. Diltiazem (Cardizem)
3. Metoprolol (Lopressor)
4. Docusate sodium (Colace)

(4) Docusate sodium (Colace) is a stool softener that will relieve associated constipation from bed rest and narcotic administration. The remaining medications have other indications.

**139.** A client with left-sided heart failure will have which of the following signs or symptoms?

1. pedal edema
2. hepatomegaly
3. shortness of breath
4. jugular vein distension

(3) A client with left-sided heart failure will have shortness of breath due to pulmonary congestion. The remaining options are indicative of right-sided heart failure.

**140.** For a client that has become unresponsive after going into ventricular fibrillation, what is the *first* response of the nurse?

1. Check for breathing.
2. Administer cardioversion.
3. Open the airway.
4. Give intravenous lidocaine.

(3) The first response should be to open the airway. The remaining actions are done afterward. Remember A-B-C: Airway, Breathing, Circulation, in that order.

**141.** Which of the following signs or symptoms are indicative of deep vein thrombosis?

1. coolness of the leg
2. unilateral leg edema
3. weak pedal pulse
4. cyanosis of the leg

(2) Unilateral leg edema is indicative of deep vein thrombosis. The remaining options are found with other conditions.

**142.** Your patient with Parkinson's disease has difficulty performing voluntary movements. This is known as:

1. akinesia.
2. dyskinesia.
3. chorea.
4. dystonia.

(2) Dyskinesia, an impairment of the ability to execute voluntary muscles, is known as shaking palsy. Parkinson's disease is a disease of brain degeneration that appears gradually and progresses slowly. It is a chronic disease that usually develops late in life and can be very disabling. Early symptoms include mild tremors of the hands and a nodding movement of the head. The patient is likely to fall frequently, as postural reflexes are lost; as the disease progresses, muscular movements become slower and more difficult. The stiffness of the muscles affects the facial expressions, making them rigid and mask-like. A characteristic tremor develops in the fingers, referred to as a pill-rolling tremor that disappears with voluntary movement of the hands. The posture is stooped. The forward-leaning position causes a peculiar gait of short, running steps to maintain balance.

**143.** A patient who is newly diagnosed with Parkinson's disease and beginning medication therapy asks the nurse, "How soon will improvement occur?" The nurse's best response is:

1. "That varies from patient to patient."
2. "You should discuss that with your physician."
3. "You should notice a difference in a few days."
4. "It may take several weeks before you notice any degree of improvement."

(4) Three obvious signs of Parkinson's disease are bradykinesia (slowness of movement), tremor, and rigidity. Actions that were once automatic become deliberate. Experts recommend frequent brief rests, moving slowly, and learning how to manage difficult movements such as descending stairs. The most important factor in maintaining flexibility, motility, and mental well-being is prescribed exercise. Relaxation is particularly important for PD patients as stressful situations worsen the condition. The generation of nerve cells occurs in the basal ganglia, the nerve centers responsible for regulation of certain involuntary body movements; it has been discovered that a neuronal transmitter substance, dopamine, is inadequately produced; treatment includes the administration of L-dopa, a substance that is converted to dopamine in the brain—although the drug therapy does not stop the patient with previous mental disorders or cardiovascular disease—alcohol consumption should be limited because alcohol acts antagonistically to L-dopa; other drug therapy includes dopaminergics, anticholinergics, and antihistamines; with all therapies, including rehabilitation and drugs, it will depend upon the extent and progression of the Parkinson's disease as well as the necessity of being on the prescribed therapy for several weeks.

**144.** The client with diabetes mellitus needs to have education on the appropriate diet for her newly diagnosed condition. The nurse states:

1. “You can eat anything you want, but no foods with sugar.”
2. “You need to lose weight, so your diet will be a restricted one.”
3. “You will need to have a diet and exercise program to meet your needs.”
4. “You must eliminate all salt, fat, and sugar in your diet.”

(3) Three components of treatment include: nutrition, exercise, and medications; overall goal is to make changes in nutrition and exercise habits for improved metabolic control of carbohydrate metabolism to normalize blood glucose levels (fasting: 70–140 mg/dL); diabetes mellitus is a metabolic disorder of carbohydrates (CHO) metabolism, leading to altered glucose regulation and utilization as a result of insufficient or ineffective insulin.

**145.** A client comes to the clinic for assessment of his physical status and guidelines for starting a weight reduction diet. The client’s weight is 216 lbs, and his height is 66 inches. The nurse identifies the BMI (body mass index) as:

1. Within normal limits, so a weight reduction diet is unnecessary.
2. Lower than normal, so education about nutrient dense foods is needed.
3. Indicating obesity because the BMI is 35.
4. Indicating overweight status, because the BMI is 27.

(3) Obesity is defined by BMI (body mass index) of 30 or above with no co-morbid conditions. It is calculated by utilizing a chart or nomogram that plots height and weight. This client’s BMI is 35, indicating obesity; obesity is a fat cell development as a result of hyperplasia (an increase in number of cells), and hypertrophy (an increase in size of cells) leads to an increase in fat cell deposition. Genetic factors include leptin, uncoupling proteins, and the amount of brown/white fat in the body. Goals of diet therapy are aimed at decreasing weight to a healthy level based on client’s BMI, activity status, and energy requirements (basal energy expenditure on BEE).

**146.** The nurse would utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

1. triceps skin fold measurement
2. fasting blood glucose level
3. hemoglobin A<sub>1c</sub> level
4. serum lipid profile results

(1) Objective anthropometric measurements such as triceps skin fold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. Although all of the other choices represent tests that may provide useful information, they also may be affected by variables other than malnutrition.

**147.** The nurse would make which of the following responses when questioned by a client about the role of leptin in the body?

1. “It increases food intake in clients thereby promoting obesity.”
2. “It assists in the regulation of steroid.”
3. “It increases the total fat mass of people who are obese.”
4. “It decreases the total fat mass in the body in people who are obese.”

(4) Leptin (recessive obesity gene—protein hormone) is expressed in fat cells’ coding for the protein that reacts to the percentage of fat cells in the body; leptin works to increase energy expenditure and decrease food intake via hypothalamic control; obese clients have insensitivity or resistance to the effects of leptin; leptin can affect other body hormones such as insulin; genetic factors include leptin, uncoupling proteins, and amount of brown/white fat in the body.



**148.** What are the implications for a client with renal insufficiency who wants to start a low-carbohydrate (CHO) diet?

1. As long as the client eats a minimum of 30g of CHO/day, there should be no problem.
2. The client's clinical condition is a contraindication to starting a low CHO diet.
3. Calcium supplements should be utilized to prevent the development of osteoporosis while on a low CHO diet.
4. As long as the client eats foods that are high biologic protein sources, there will be no problems with following a low CHO diet.

(2) A client with renal insufficiency should not start a low CHO diet; this implies that protein and fat levels will be increased, resulting in an increased renal solute load. Clients who have renal disease (renal failure, endstage renal disease or ESRD, dialysis, and transplant) or liver disease (liver failure, hepatic encephalopathy, cirrhosis, transplant, and hepatitis) require some form of protein control in dietary pattern to prevent complications from inability to handle protein solute load; proteins used in the diet must be of high biologic value and protein intake is usually weight-based, starting at 0.8 g/kg of dry weight, depending on the client's underlying clinical condition. Protein levels may be increased as necessary to account for metabolic response to dialysis and regeneration of liver tissue (1.5–2.0 g/kg/day); A minimum level of CHO's are needed in the diet (50–100 g/day) in order to spare protein; vitamin and mineral supplements may be indicated with clients who have liver failure; the dietician is instrumental in calculating specific nutrient requirements for these clients and reviewing fluid intake and output, medication profile and daily weights to monitor client outcomes in conjunction with dialysis technicians/nurses.

**149.** Herbal therapy has several indications for use, including:

1. treating many common complaints and diseases.
2. promoting certain types of "low-carb" diets.
3. being used as an adjunct to medications.
4. used with a diet without salt and carbohydrates.

(1) Indications for use and availability: They are used to treat many common health complaints and disease states ranging from headaches to clinical depression. Their availability in natural food products, packaged supplements, and OTC preparations can lead to confusion about reliable sources and bioavailability. Since this is a developing field, additional interest and research is being generated to obtain a more standardized approach to labeling and stricter regulation of products.

**150.** Which of the following statements would the nurse use to best describe a very-low-calorie diet (VLCD) to a client?

1. "This diet can be used when there is close medical supervision."
2. "This is a long-term treatment measure that will assist obese people who can't lose weight."
3. "The VLCD consists of solid food items that are pureed to facilitate digestion and absorption."
4. "A VLCD diet contains very little protein."

(1) VLCD diets are used in the clinical treatment of obesity under close medical supervision; the diet is low in calories, high in quality of protein, and has a minimum of carbohydrates in order to spare protein and prevent ketosis.

**151.** When explaining to a group of adolescents why creatine is being suggested as beneficial for athletic performance, the nurse would state that creatine:

1. is an efficient fuel source in the body that promotes catabolic effects.
2. is effective for long-term endurance performance.
3. decreases lean body mass and increases muscle strength.
4. assists the body in repetitive short-term activity that requires energy bursts.

(4) Creatine has been demonstrated to improve the body's response in an exercise pattern consisting of repetitive short-term activities; promotes anabolism.

**152.** A client states that he is considering using herbal therapy as a natural source to aid in dietary health. What suggestions would you give to the client to assist with this decision?

1. “Herbal therapy treatments reflect standard doses so all similar products will provide the same biologic effect.”
2. “Herbal therapy requires a prescription and may be an expensive treatment modality.”
3. “It is important to inform your healthcare practitioner about your choice to start herbal therapy.”
4. “Herbal therapy is a natural form of treatment with very few side effects.”

(3) It is important to inform the healthcare provider at the start of herbal, because this can prevent problems from potential drug interactions, verify indication for therapy, and acknowledge client’s concerns over common complaints; client should read all labels critically for ingredients/side effects/other.

**153.** Which of the following problems can arise when a client taking anticoagulant therapy eats a large amount of garlic?

1. The garlic will assist in the coagulation process and accelerate clot formation.
2. None; garlic has no effect on blood coagulation.
3. None; garlic helps to support immune function.
4. Bleeding can occur because garlic inhibits platelet aggregation.

(4) Garlic is a food/herbal supplement that has long been recognized for its health benefits (lowers cholesterol/triglycerides, improves immune function, and decreases blood pressure). Garlic can inhibit platelet aggregation and, therefore, prevents blood clot formation. A client who is on anticoagulation therapy should be advised of potential interaction with excessive amounts of garlic in the diet.

**154.** A postoperative surgical patient develops pain, redness, and edema in the calf. These symptoms may potentially indicate which of the following conditions?

1. arterial embolism
2. varicose veins
3. thrombophlebitis
4. lymphedema

(3) Pain, redness, and edema in the calf of a postoperative patient indicates thrombophlebitis, resulting from venous stasis. Venous thrombosis (thrombophlebitis) refers to inflammation of a vein precipitating thrombus (blood clot) formation; it almost always occurs in the neck veins or occasionally in the trunk. Types of venous thrombosis include: a) Deep Vein Thrombosis (DVT), a stationary clot that forms in the deeper veins of the legs; b) Superficial thrombophlebitis, an inflammation of a more superficial vein closer to the surface; this condition is accompanied by formation of a stationary clot within the vein. Phlebothrombosis refers to thrombus formation without venous inflammation. Phlebitis refers to inflammation of one or more veins without resultant clot formation. Thrombi formation is believed to occur when both venous stasis and hypercoagulability exist. Stagnated blood will accumulate in the pocket areas of the vessel valves, resulting in hypercoagulability (because activated coagulation factors are not removed from the blood). Traces of thrombin activate the clotting mechanisms of platelet aggregation and conversion of fibrinogen to fibrin. Trauma or damage to the vessel walls from an injury or phlebitis may cause platelet adhesion to the vein wall. DVT and phlebitis are acute diseases that may result in pulmonary embolism (as pieces of the clot break off and travel to the lung) or chronic venous insufficiency.

**155.** Raynaud’s disease is characterized mainly by:

1. an emboli stemming from thrombus formation in the cardiac chambers.
2. episodes of arteriospasm with resultant ischemia in the extremities.
3. episodes of hypertension and constriction of the vessels.
4. seccular aneurysms caused by trauma.

(2) Raynaud's disease and Raynaud's phenomenon are characterized by: episodes of arteriospasm with resultant ischemia in the extremities, particularly the digits of the hands; the clinical findings of the disease and the phenomenon are the same, but the etiologies are different. Raynaud's phenomenon occurs secondary to other disorders including: a) occlusive arterial diseases (for example, arteriosclerosis obliterans and thromboangiitis obliterans); b) connective tissue diseases (for example, systemic scleroderma, lupus erythematosus, and dermatomyositis); c) primary pulmonary hypertension; d) hypothyroidism; e) neurologic diseases (for example, central or peripheral neuropathy and carpal tunnel syndrome). Episodes are manifested by color changes of the affected areas: a) Biphasic changes: cyanosis and then reactive hyperemia occurs; b) Triphasic changes: Pallor and then cyanosis may occur when the vasospasm results in arterial occlusion; reactive hyperemia occurs in response to the ischemic changes (hypoxia-induced vasodilatation).

**156.** Psoriasis may be caused by all of the following except:

1. contact with an infected person.
2. biochemical alteration.
3. genetic predisposition.
4. familial predisposition.

(1) Psoriasis is not a contagious disease and is not spread by contact with lesions; psoriasis is a chronic inflammatory papulosquamous condition resulting in silvery, scaly patches due to epidermal overgrowth; genetic or biochemical alterations may be involved in the etiology. When keratinocytes mature, they move up and out from the inner layer to replace the skin surface. As they move, they flatten, dehydrate, and become keratinized. In psoriasis, this process is speeded up so that, instead of epidermal replacement occurring every 21 days, it occurs every 5 days. Vasodilation of dermal vessels and leukocyte accumulation into the dermis result in erythema. Because of the increased mitotic rate, keratinization does not occur and the skin's protective mechanism is impaired. Lesions most commonly occur on the elbows, knees, and scalp and are clearly demarcated.

**157.** During vomiting, there is:

1. forceful diaphragm and abdominal muscle contractions, airway closure, esophageal sphincter relaxation and deep inspiration.
2. deep inspiration, airway closure, forceful diaphragm and abdominal muscle contractions, and esophageal sphincter relaxation.
3. airway closure, forceful diaphragm and abdominal muscle contractions, deep inspiration, and esophageal sphincter relaxation.
4. esophageal sphincter relaxation, forceful diaphragm and abdominal muscle contractions, deep inspiration, and airway closure.

(2) Vomiting is the forceful emptying of stomach and intestinal contents of chyme through the mouth. The vomiting reflex is stimulated by presence of ipecac or copper salts in the duodenum, severe pain, or distention of the stomach or duodenum. Torsion or trauma affecting the ovaries, testes, uterus, bladder, or kidney also elicit vomiting; vomiting occurs when the stomach is full of gastric contents and the diaphragm is forced high into the thoracic cavity by strong abdominal muscle contractions. The higher intrathoracic pressure forces the upper esophageal sphincter to open and chyme is discharged from the mouth.

**158.** Gastroesophageal reflux is:

1. caused by rapid gastric emptying.
2. excessive lower esophageal sphincter functioning.
3. associated with abdominal surgery.
4. caused by spontaneously relaxing lower esophageal sphincter.

(4) Gastroesophageal reflux (chyme reflux into esophagus); increased abdominal pressure, ulcers, pyloric edema and strictures, hiatal hernia; regurgitation of chyme within one hour of eating.

**159.** Intestinal obstruction causes:

1. decreased intraluminal tension.
2. hyperkalemia.
3. decreased nutrient absorption.
4. both 1 and 2 are correct.

(3) Intestinal obstruction (impaired chyme flow through intestinal lumen); hernia, telescoping of one part of intestine into another, twisting, inflamed diverticular, tumor growth, loss of peristaltic activity; “Colicky” pain to severe and constant pain, vomiting, diarrhea, constipation, dehydration and hypovolemia, and acidosis with their complications.

**160.** In malabsorption syndrome, flatulence and abdominal distension are likely caused by:

1. protein deficiency and electrolyte imbalance.
2. undigested lactose fermentation by bacteria.
3. fat irritating the bowel.
4. impaired absorption of amino acids and accompanying edema.

(2) Malabsorption syndromes interfere with nutrient absorption in the small intestine; the intestinal mucosa fails to absorb or transport the digested nutrients into the blood; Malabsorption is the result of mucosal disruption caused by gastric or intestinal resection, vascular disorders, or intestinal disease.

**161.** The characteristic lesion of Crohn’s disease is:

1. found in the ileum.
2. precancerous.
3. granulomatous.
4. both A and C are correct.

(4) Crohn’s disease is an inflammatory disease of the intestine that affects most frequently young adults (particularly females); the intestinal walls become thick and rigid; as the wall thickens with the formation of fibrous tissue, the lumen is narrowed and a chronic obstruction can develop; frequently an alteration between diarrhea and constipation; melena, dark stools, containing blood pigments is common.

**162.** Adult onset obesity usually is:

1. both hyperplastic and hypertrophic.
2. dispelled over the entire body.
3. hypotrophic.
4. unrelated to the genotype.

(1) Overnutrition or excessive caloric intake leads to obesity or excessive body fat; classified by cause as either exogenous, resulting from an excess of ingested calories or endogenous, resulting from inherent metabolic problems. Physiologically, obesity can be hyperplastic, caused by a greater-than-normal number of fat cells; or hypertrophic, caused by greater-than-normal size of fat cells.

**163.** In pancreatitis:

1. the tissue damage likely results from release of pancreatic enzymes.
2. high cholesterol intake is causative.
3. diabetes is uncommon in chronic pancreatitis.
4. bacterial infection is the etiological cause.

(1) Pancreatitis or inflammation of the pancreas, potentially serious disorder, develops because of an injury or disruption of the pancreatic ducts or acini that permits leakage of pancreatic enzymes into pancreatic tissue; the leaked enzymes

initiate auto digestion and acute pancreatitis; bile reflux into the pancreas occurs if gallstones obstruct the common bile duct; the refluxed bile also injures pancreatic tissue; toxic enzymes also are released into the bloodstream and cause injury to vessels and other organs such as the lungs and kidneys.

**164.** Which medication would be used to decrease a chemotherapy client's nausea and vomiting?

1. Dexamethasone (Decadron)
2. Methylcellulose (Citrucel)
3. Phentolamine mesylate (Regitine)
4. Metoclopramide (Reglan)

(4) Metoclopramide (Reglan) is a cholinergic medication used to prevent the nausea and vomiting associated with chemotherapy and delayed gastric emptying. Phentolamine mesylate (Regitine) is an alpha-adrenergic blocker used for treating hypertension. Methylcellulose (Citrucel) is a bulk laxative. Dexamethasone (Decadron) is a corticosteroid used to treat cerebral edema.

**165.** A 54-year-old man is admitted to the hospital for a colostomy related to a recent diagnosis of colon cancer. During the preoperative period, what is the most important aspect of this client's nursing care?

1. Assure the client that he will be cured of cancer.
2. Assess understanding of the procedure and expectation of bodily appearance after surgery.
3. Maintain a cheerful and optimistic environment.
4. Keep visitors to a minimum, so that he can have time to think things through.

(2) False reassurance that everything will be all right is inappropriate. It is a block to therapeutic communication and it discounts the client's feelings. The client should understand the extent of surgery and type and care of the ostomy. Although a cheerful, optimistic environment is important, it is essential that the client understand the proposed surgical treatment. Visitors should not be restricted. Family and friends can provide valuable social support to the client.

**166.** A client who is getting radiation asks the nurse why these sores developed in the client's mouth. What is the most appropriate response?

1. "Don't worry; it always happens with radiation."
2. "Your oral hygiene needs improvement."
3. "It is a sign that the radiation is effective."
4. "The sores result because the cells in the mouth are sensitive to the radiation."

(4) Epithelial cells are extremely sensitive to radiation therapy, because of their normally high rate of cell turnover. The client deserves an honest, supportive answer.

**167.** A client develops stomatitis during the course of radiation therapy. Nursing care for this problem should include:

1. a soft, bland diet.
2. restricting fluids to decrease salivation.
3. rinsing the mouth every two hours with a dilute mouthwash.
4. encouraging the client to drink hot liquids.

(1) Bland foods of moderate temperature facilitate swallowing and decrease pain. Fluids should be encouraged to keep oral membranes moist and to decrease side effects of chemotherapy. Commercial mouthwashes should be avoided because of their alcohol content. The mouth should be rinsed with dilute H<sub>2</sub>O<sub>2</sub> or normal saline solution. Lemon-glycerin swabs should be avoided to prevent excessive drying of the oral mucosa.

**168.** The chemotherapeutic agent 5-fluorouracil (5-FU) is ordered for a client as an adjunct measure to surgery. Which statement about chemotherapy is true?

1. It is a local treatment affecting only tumor cells.
2. It is a systemic treatment affecting both tumor and normal cells.
3. It has not yet been proved an effective treatment for cancer.
4. It is often the drug of choice because it causes few if any side effects.

(2) 5-Fluorouracil (5-FU) is an antineoplastic, antimetabolic drug that inhibits DNA synthesis and interferes with cell replication. It is given intravenously and acts systemically. It affects all rapidly growing cells, both malignant and normal. It is used as adjunct therapy for treating cancer of the colon, rectum, stomach, breast, and pancreas. This drug has many side effects, including bone marrow depression, anorexia, stomatitis, and nausea and vomiting.

**169.** Which instruction should be given in a health education class regarding testicular cancer?

1. All males should perform a testicular exam after the age of 30.
2. Testicular exams should be performed on a daily basis.
3. Reddening or darkening of the scrotum is a normal finding.
4. Testicular exams should be performed after a warm bath or shower.

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

**170.** During surgery, it is found that a client with adenocarcinoma of the rectum has positive peritoneal lymph nodes. What is the next most likely site of metastasis?

1. brain
2. bone
3. liver
4. mediastinum

(3) Colon tumors tend to spread through the lymphatics and portal vein to the liver. Although metastasis to the other sites listed is possible, the liver is most likely the first to be affected.

**171.** Medical treatment for a client with cervical cancer will include a hysterectomy followed by internal radiation. Although she is 32 years old and has three children, the client tells the nurse that she is anxious regarding the impending treatment and loss of her femininity. Which interaction is most appropriate?

1. Tell the client that now she does not have to worry about pregnancy.
2. Provide the client with adequate information about the effects of treatment on sexual functioning.
3. Refer her to the physician.
4. Avoid the question. Nurses are not specialists in providing sexual counseling.

(2) Many women with cervical cancer fear a loss of femininity. It is important to discuss the effects of treatment to enable the client to prepare for changes in sexual functioning. Although telling the client that she does not have to worry about pregnancy is accurate, it is not a therapeutic response. Nurses are capable of answering questions regarding sexuality. The client will need to be referred to other resources if the client's concerns cannot be addressed by the nurse; the physician should be notified of the client's concerns, but not necessarily as a referral.

**172.** A client receives a cervical intracavity radium implant as part of her therapy. A common side effect of a cervical implant is:

1. creamy, pink-tinged vaginal drainage.
2. stomatitis.
3. constipation.
4. xerostomia.

(1) Vaginal drainage will persist for 1–2 months after removal of a cervical implant. Diarrhea, not constipation, is usually a side effect of cervical implants; stomatitis and xerostomia are local side effects of radiation to the mouth.

**173.** A client's care plan during the time that she has a cervical implant in place would include with intervention?

1. frequent ambulation
2. unlimited visitors
3. low-residue diet
4. vaginal irrigations every shift

(3) Clients with cervical implants require a low-residue diet (and often antidiarrheal medications) to reduce the frequency of defecation. Defecation may cause accidental dislodgement of the implant from straining and sitting on a bedpan. Frequent ambulation is contraindicated because it will dislodge the implant. Bed rest in a supine or low Fowler's position should be maintained. Visitors should be limited to one 15-minute visit a day, and no pregnant women or children should be allowed because of the radiation exposure. Vaginal irrigations are contraindicated during this period of time.

**174.** Which finding is a long-term side effect of a cervical radium implant?

1. shortening and narrowing of the vagina
2. nausea
3. uterine cramping
4. diarrhea

(1) Shortening and narrowing of the vagina is a distressing long-term complication of cervical implants. Women need to use a vaginal dilator twice a week to stretch the tissue. Uterine cramping is a temporary side effect that occurs only if the implant extends into the uterus. Nausea and diarrhea may occur during the initial treatment but are not long-term side effects.

**175.** When a client is having external radiation for lung cancer, what side effect is most likely to be experienced?

1. alopecia
2. bone marrow suppression
3. stomatitis
4. dyspnea

(4) The majority of side effects of external radiation are dependent on the specific site being radiated. Because the client's cancer site is the lung, radiation will result in irritation of the lung mucosa, resulting in dyspnea.

**176.** Nursing management of a client's irradiated skin will *not* include which of the following?

1. applying A and D Ointment prn to relieve dry skin between treatments
2. cleansing the skin with tepid water and a soft cloth
3. avoiding direct exposure to the sun
4. redrawing the skin markings if they are accidentally removed

(4) Skin markings must not be removed in any way. If they are inadvertently washed off, markings are redrawn only by the radiation technician.

**177.** A 25-year-old male client receiving external radiation treatments tells you that he fears he is radioactive and a danger to his family and friends. How would the nurse dispel his fears?

1. Inform him that radiation machines are risk free.
2. Explain that once the machine is off, radiation is no longer emitted.
3. Avoid telling him that his fears are in fact true.
4. Instruct him to spend short periods of time with his family and friends.

(2) It is important to understand the difference between external and internal radiation so that the nurse can be accurate when correcting the client's misconceptions. He is not radioactive and does not need to limit contact with others.

**178.** The nurse assesses for findings of early cervical cancer by which of the following?

1. a dark, foul-smelling vaginal discharge
2. pressure on the bladder or bowel, or both
3. back and leg pain and weight loss
4. vaginal discharge (leucorrhea)

(4) The two chief symptoms of cancer of the cervix are metrorrhagia (vaginal bleeding or spotting at irregular intervals and between periods) and a watery vaginal discharge.

**179.** The nurse discusses with a client in the healthcare clinic the possibility of endometrial cancer. Which of the following statements is *incorrect* concerning endometrial cancer?

1. Diagnosis is most frequently established by a dilation and curettage (D&C).
2. Prolonged use of exogenous estrogen increases the occurrence.
3. The first and most important symptom is abnormal bleeding.
4. This malignancy tends to spread rapidly to other organs.

(4) Cancer of the endometrium tends to be slow spreading. After it has spread to the cervix, invaded the myometrium, or spread outside the uterus, the prognosis is poor.

**180.** The Pap smear reveals that a client has cancer of the cervix. The mode of treatment is an abdominal hysterectomy. The client voices concern about undergoing menopause. In counseling her, which statement would be most appropriate?

1. A surgical menopause will occur, and treatment with estrogen therapy will be necessary.
2. The ovaries will continue to function and produce estrogen, thus preventing menopause as a result of surgery.
3. Ovarian hormone secretion ceases, but the hypothalamus will continue to secrete FSH, and this prevents menopause.
4. The ovaries will cease functioning, and it will be necessary to take estrogen.

(2) Menstruation will cease after a hysterectomy, but as long as the ovaries are left in place, they will continue to function, and surgical menopause will not occur. A hysterectomy is removal of the uterus and usually the cervix.

**181.** Which of the following statements is true about lead-poisoning?

1. The child suffering from acute lead intoxication presents a medical emergency.
2. It is hard to detect since lead is normally present in the blood.
3. It is a silent disease, because there are no warning signs or chronic symptoms.
4. None of the above.

(1) A toxic condition caused by ingestion or inhalation of lead or lead compounds; the acute form of intoxication is characterized by a burning sensation in the mouth and esophagus, colic, constipation, or diarrhea, mental disturbances, and paralysis of the extremities, followed in severe cases by convulsions and muscular collapse. If ingested, treatment



commences with gastric lavage with magnesium or sodium sulfate, fluid therapy followed by chelation with IM injection of calcium disodium edentate, or for severe cases, British antilewisite. Encephalopathy must be anticipated in children with lead poisoning.

**182.** The diagnostic investigation of a congenital heart defect may include:

1. physical examination and patient history.
2. chest x-ray and blood tests.
3. heart catheterization and electrocardiogram.
4. all of the above.

(4) Congenital heart defect is any structural or functional abnormality or defect of the heart or great vessels existing from birth. General physical symptoms of these patho-physiologic alterations are growth retardation, decreased activity, recurrent respiratory infections, dyspnea, tachycardia, cyanosis, and murmurs. Diagnosis is by physical exam and history, chest x-ray, laboratory tests; heart catheterization and electrocardiogram.

**183.** A diagnostic test for tuberculosis is:

1. hemoglobin electrophoresis.
2. chest radiography.
3. cardiac catheterization.
4. blood test.

(2) Chest radiography is a prime diagnostic evaluation for tuberculosis. Others include a PPD skin test and gastric aspirations. TB is contracted from another person with the disease by inhalation of droplets from coughing, sneezing, or spitting; assessment of client's history, past and present signs and symptoms.

**184.** Cancer of the lungs is caused by:

1. airway atresia.
2. hepatitis A.
3. cigarette smoking.
4. congenital defects.

(3) Lung cancer is a malignant tumor of lung tissue. Causes are cigarette smoking, air pollution, arsenic, asbestos, and radioactive dust. Cancer of the lungs can be diagnosed with chest radiography, bronchoscopy, tissue biopsy, or mediastinoscopy.

**185.** A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least necessary at this time?

1. Test all excreta for occult blood.
2. Use a soft toothbrush or foam cleaner for oral hygiene.
3. Implement reverse isolation.
4. Avoid IM injections.

(3) It is not necessary because it will not affect the risk of hemorrhage.

**186.** High uric acid levels may develop in clients who are receiving chemotherapy. This is caused by:

1. the inability of the kidneys to excrete the drug metabolites.
2. rapid cell catabolism.
3. toxic effects of the prophylactic antibiotics that are given concurrently.
4. the altered blood pH from the acid medium of the drugs.

(2) When chemotherapy is initiated, there is a breakdown of many cancer cells. Uric acid is a cell metabolite.

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

1. Prednisone (Colisone).
2. Allopurinol (Zyloprim).
3. Indomethacin (Indocin).
4. Hydrochlorothiazide (HydroDiuril).

(2) Allopurinol is an antigout drug that decreases uric acid formation. Prednisone is a corticosteroid used for immuno-suppression and severe inflammation. Indomethacin inhibits prostaglandin synthesis; it is effective as an analgesic, anti-inflammatory, and antipyretic agent. Hydrochlorothiazide is a thiazide diuretic that is effective in hypertension and edema.

**188.** Nursing care for the client undergoing chemotherapy includes assessment for signs of bone marrow depression. Which finding accounts for some of the symptoms related to bone marrow depression?

1. Erythrocytes
2. Leukocytosis
3. Polycythemia
4. Thrombocytopenia

(4) Thrombocytopenia is an abnormal decrease in the number of platelets, which results in bleeding tendencies. Erythrocytosis is an abnormal increase in the number of circulating red blood cells. Leukocytosis is an increase in the number of white blood cells in the blood. Polycythemia is also an excess of red blood cells and is a synonym for erythrocytosis. With chemotherapy there is a decrease in red and white blood cells, not an increase.

**189.** A woman is in the active phase of labor. An external monitor has been applied, and a fetal heart deceleration of uniform shape is observed, beginning just as the contraction is underway and returning to the baseline at the end of the contraction. Which of the following nursing actions is most appropriate?

1. Administer O<sub>2</sub>.
2. Turn the client on her left side.
3. Notify the physician.
4. No action is necessary.

(4) It is an early deceleration as a result of head compression, and at this time there is no action; further close observation of the mother and baby is needed.

**190.** A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

1. pain on movement and weight bearing
2. hemorrhage
3. affected leg 1–2 inches longer
4. edema in the area of the incision

(1) Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation; other symptoms of dislocation include inability to bear weight and a shortening of the affected leg; edema is not a primary sign of displacement.

**191.** Paula is a 32-year-old seeking evaluation and treatment of major depressive symptoms. A major nursing priority during the assessment process includes which of the following?

1. meaning of current stressors
2. possibility of self-harm
3. motivation to participate in treatment
4. presence of alcohol or other drug use

(2) Unless the client is first assessed for self-harm or suicide potential, the staff will not observe the necessary degree of vigilance needed in the client's environment. Physical needs are the second most critical concern with a depressive client. Although the client may be encouraged to attend group therapy as part of the treatment plan, the client's safety takes precedence. Response to medication takes time and is not an initial concern.

**192.** Ten-year-old Jackie is admitted to the hospital with a medical diagnosis of rheumatic fever. She relates a history of "a sore throat about a month ago." Bedrest with bathroom privileges is prescribed. Which of the following nursing assessments would be given highest priority when assessing Jackie's condition?

1. Jackie's response to being hospitalized
2. the presence of a macular rash on her trunk
3. her sleeping or resting apical pulse
4. the presence of polyarthritis and pain in her joints

(3) The only permanent damage that may result from rheumatic fever is cardiac damage; therefore, close monitoring of cardiac status is imperative.

**193.** A 21-year-old college student has just learned that she contracted genital herpes from her sexual partner. After completing the initial history and assessment the nurse will have data concerning areas pertinent to the disease. Which of the following would be *unnecessary* to include at this point?

1. voiding patterns
2. characteristics of lesions
3. vaginal discharge
4. prior history of varicella

(4) The other options list common reasons for which the client with herpes seek care.

**194.** The client has been admitted in septic shock. Her nursing care plan includes the diagnosis High Risk for Injury related to clotting disorder. Based on this diagnosis, all the following would be appropriate entries in the nursing care plan *except*:

1. obtain an order for a stool softener.
2. administer packed RBCs, if necessary.
3. encourage the client to rinse her mouth with mouthwash and scrub her teeth with an oral sponge.
4. dress venipuncture sites immediately to prevent infection.

(4) Firm direct pressure should be applied to the site for 3–7 minutes before final dressing because of the clotting abnormality; septic shock is a systemic infection of the blood stream producing clinical manifestations—warm flushed skin; high urine output, tachycardia, edema, respiratory problems, restlessness, altered level of consciousness; life threatening form of shock.

**195.** A person using over-the-counter nasal decongestant drops who reports unrelieved and worsening nasal congestion should be instructed to:

1. switch to a stronger dosage of the medication.
2. discontinue the medication for a few weeks.
3. continue taking the same medication, but use it more frequently.
4. use a combination of medications for better relief.

(2) Prolonged use of decongestant drops (3–5 days) can lead to rebound congestion, which is relieved by discontinuing the medication for 2 or 3 weeks; nasal congestion results from dilation of nasal blood vessels due to infection, inflammation, or allergy. With this dilation, there is a transudation of fluid into the tissue spaces, resulting in swelling of the nasal cavity. Nasal decongestants (sympathomimetic amines) stimulate the alpha-adrenergic receptors, thus producing vascular constriction (vasoconstriction) of the capillaries within the nasal mucosa. The result is shrinking of the nasal mucous

membranes and a reduction in fluid secretion (runny nose); decongestants can make a client jittery, nervous, or restless. These side effects decrease or disappear as the body adjusts to the drug.

Usage of nasal decongestants longer than 5 days could result in rebound nasal congestion. Instead of the nasal membranes constricting, vasodilation occurs, causing increased stuffy nose and nasal congestion. The nurse should emphasize the importance of limiting the use of nasal sprays and drops.

As with any alpha-adrenergic drug (for example, decongestants), blood pressure and blood glucose levels can increase. These drugs are contraindicated or to be used with extreme caution for clients having hypertension, cardiac disease, hyperthyroidism, and diabetes mellitus.

**196.** What emergency intervention may be necessary for the postoperative thyroidectomy patient experiencing hemorrhage?

1. intravenous calcium
2. oral airway insertion
3. tracheostomy
4. intravenous thyroid hormone

(3) Hemorrhage in the postoperative thyroidectomy patient may cause compression of the trachea, necessitating emergency tracheostomy to maintain an airway; thyroidectomy—the surgical removal of the thyroid gland, performed for colloid goiter, tumors, or hyperthyroidism that does not respond to iodine therapy and antithyroid drugs. All but 5 to 10 percent of the gland is removed; regrowth usually begins shortly after surgery, and thyroid function may return to normal. For cancer of the thyroid, the entire gland is removed, along with surrounding structures from neck to collarbone, in a radical neck dissection. Before surgery, the basal metabolism rate is lowered to normal by giving iodine and antithyroid drugs. If a tumor is present, a frozen section of the affected tissue is examined by a pathologist. If malignant cells are found, most of all of the gland is removed. After surgery, the patient is most comfortable in semi-Fowler's position with continuous mist inhalation administered to liquefy oral secretions. Oral suctioning may be necessary. A tracheotomy set and oxygen are kept in the room. Postoperatively, the patient is observed for signs of hemorrhage, respiratory difficulty caused by edema of the glottis, the muscular twitching of tetany from accidental removal of a parathyroid gland, and thyroid storm.

**197.** Lung dysfunction impacts physical and mental performance because of the lungs' critical role in maintaining the body's acid-base balance. Specifically, the lung plays a primary role in controlling:

1. arterial  $O_2$  and blood urea.
2. arterial  $CO_2$  and cholesterol.
3. arterial  $CO_2$ , serum albumin, and pH.
4. arterial  $CO_2$  and pH.

(4)  $CO_2$  and  $H_2O$  in differing concentrations, react to form carbonic acid ( $H_2CO_3$ ), which in turn dissociates to form bicarbonate ( $HCO_3$ ) and hydrogen ( $H^+$ ) ions. This reaction determines the pH of arterial blood and the acid-base balance of the human body.  $CO_2$  is blown off or conserved by the lungs as one variable in keeping this balance.

**198.** Interventions to relieve the discomfort associated with chronic arterial occlusive vascular disease should be directed as:

1. improving venous return from the involved extremity.
2. avoiding narcotic analgesic medications.
3. preventing edema in the extremities.
4. increasing circulation to the extremities.

(4) Improving circulation decreases ischemia, the basic cause of pain in arterial occlusive disorder. Arterial insufficiency is an inadequate blood flow in arteries caused by damaged, diseased, or intrinsically weak vessels, by arteriovenous fistulas, by aneurysms, by hypercoagulability states, or by heavy use of tobacco. Signs of arterial inadequacy include pale, cyanotic, or mottled skin over the affected area, absent or decreased sensations, tingling, diminished sense of temperature,

muscle pains, as intermittent claudication in the calf before continuous exercise, reduced or absent peripheral pulses, and, in disease, atrophy of muscles of the involved extremity. Arterial insufficiency may be diagnosed by checking and comparing peripheral pulses in contralateral extremities, by angiography, by ultrasound using a device, and by skin temperature tests. Normally immersion of an extremity in hot water increases the skin temperature of the opposite limb, but this usually does not occur in arterial disease; immersion of the patient's hand in ice water raises the blood pressure about 45 mmHg and the pulse pressure 20 mmHg, whereas in the normal individual the blood pressure increases only 25 mmHg and the pulse pressure does not change. Treatment of arterial insufficiency may include a diet low in saturated fats, moderate exercise, sleeping on a firm mattress, the use of a vasodilator and, if indicated, surgical repair of an aneurysm or arteriovenous fistula. Smoking, prolonged standing, and sitting with the knees bent are discouraged.

**199.** A male client has been diagnosed with *Chlamydia trachomatis* infection. The plan of care should include which of the following?

1. instructions to take all of the doxycycline (Vibra-tabs) that was ordered
2. encouragement to use condoms with most episodes of intercourse
3. obtaining the names of sexual contacts if client desires
4. teaching of testicular self-exam (TSE) for diagnosis

(1) Doxycycline (Vibra-tabs) is a commonly utilized treatment for Chlamydia infections, and like all antibiotics must be taken until the medication is gone. Use of condoms with every sexual encounter decreases the transmission of sexually transmitted diseases. Sexual contacts should be notified of the infection so that appropriate testing can be obtained. This is especially important with Chlamydia because it is so often asymptomatic in women, and early detection can prevent complications such as pelvic inflammatory disease. Testicular self-exam is screening for testicular cancer, not diagnosing.

**200.** A client presents in the emergency department with fever 102°F, malaise, and a productive cough. Which of the following should be done first?

1. Administer the prescribed antibiotic.
2. Obtain a sputum culture.
3. Administer acetaminophen to lower fever.
4. Teach client the importance of hand washing.

(2) Antibiotics may affect the outcome of the culture; fever will continue to be present until the bacteria are eliminated, making administration of the antibiotic a priority.

**201.** Nursing management of incontinence includes all of the following interventions *except*:

1. bladder training.
2. increasing stimulants such as caffeine.
3. hydrating to stimulate voiding reflex.
4. maintaining hygiene to prevent infection.

(2) Increasing consumption of stimulants such as caffeine is contraindicated for the management of incontinence.

**202.** Prompt and complete treatment of acute tonsillitis caused by *A Beta-hemolytic streptococci* is necessary to prevent:

1. rheumatic fever.
2. rheumatic heart disease.
3. kidney complications.
4. all of the above.

(4) Untreated acute tonsillitis can lead to rheumatic fever, rheumatic heart disease, and kidney complications. Tonsillitis is an infection and inflammation of a tonsil. Rheumatic fever is an inflammatory disease that may develop as a delayed reaction to inadequately treated Group A beta-hemolytic streptococcal infection of the upper respiratory tract;

affected individual may also develop leukocytosis, moderate anemia, and proteinuria. Rheumatic heart disease is damage to the muscle and heart valves caused by episodes of rheumatic fever (heart murmurs); deaths are usually the result of heart failure or bacterial endocarditis.

**203.** Serious side effects of uncontrolled diarrhea in the infant or child include:

1. intestinal obstruction and rhonchi.
2. dehydration and electrolyte imbalance.
3. diaper rash and Reye's syndrome.
4. all of the above.

(2) Diarrhea is the frequent passage of loose, watery stools, generally the result of increased motility in the colon; untreated diarrhea may lead to rapid dehydration and electrolyte imbalance and should be treated symptomatically until proper diagnosis can be made. With children and infants, the rapid fluid loss can have repercussions of total body functions; this is an emergency that should immediately be taken care of.

**204.** Down's Syndrome is:

1. a congenital form of mild to severe mental retardation.
2. associated with distinctive physical abnormalities and heart defects.
3. caused by a chromosomal abnormality.
4. all of the above.

(4) Down's Syndrome is a congenital condition characterized by varying degrees of mental retardation and multiple defects. It is the most common chromosomal abnormality of a generalized syndrome and is caused by the presence of an extra chromosome 21 in G group or by the translocation of chromosomes 14 or 15 in the D group and 21 or 22.

**205.** Cerebral palsy is:

1. a result of damage to the central nervous system.
2. a condition which can be cured with treatment.
3. a condition which primarily affects intelligence.
4. all of the above.

(1) Cerebral palsy is the result of damage to the central nervous system—a motor function disorder caused by a permanent, nonprogressive brain defect or lesion present at birth or shortly thereafter—spastic hemiplegia, diplegia, ataxia, seizures, paresthesia, mental retardation, impaired speech, vision, hearing. Treatment is individualized and may include the use of braces, speech therapy, surgery, drugs.

## **PART II**

# **NCLEX-RN PRACTICE TESTS**

There are two additional practice tests on the CD-ROM.





# NCLEX-RN Practice Test 1

**Directions:** For each of the following questions, select the choice that best answers the question or completes the statement.

1. Which of the following statements, if made by a cancer patient with hair loss secondary to chemotherapy, indicates the goal for new coping patterns is being met?
  1. "I think I'll get some new barrettes for my hair."
  2. "I washed my wig today."
  3. "I asked my mom to bring my shampoo."
  4. "I'm thinking about changing my hair color."
2. A client has experienced a traumatic amputation and subsequent body image disturbance. In the record, the nurse documents the nursing diagnosis of body image disturbance related to changes in appearance secondary to:
  1. chronic disease.
  2. severe trauma.
  3. loss of body part.
  4. loss of body function.
3. Which of the following statements, when made by a client with anorexia nervosa, would indicate body image distortion instead of body image dissatisfaction?
  1. "I don't like how my body looks."
  2. "I wish I looked like my sister."
  3. "I'm sad I can't wear halter tops."
  4. "I am so overweight."
4. Which of the following questions, when asked by the nurse, assesses for the major defining characteristic of disturbed body image?
  1. "How do you feel about this disability?"
  2. "How would you describe your usual mood?"
  3. "How does your family feel about your illness?"
  4. "Do you feel fearful, anxious, or nervous?"
5. Which of the following clinical manifestations of the aging immune system should alert the nurse to increased susceptibility to illness in elder clients?
  1. increased autoimmune responses
  2. increased production of T and B cells
  3. increased lymphoid tissue
  4. increased circulating lymphocytes
6. The nurse should include all of the following information in a teaching plan for elders with altered immune responses except:
  1. "Let me go over some ways to manage stress."
  2. "It is normal for seniors to run a low grade temperature."
  3. "It is important to eat a balanced diet."
  4. "If your arthritis starts bothering you, we can give you something for pain."
7. The nurse is planning to utilize reminiscence with an elder client. The nurse's role in this intervention is:
  1. remind the client when they repeat themselves.
  2. focus on the happy memories, not the sad ones.
  3. probe for details of memories shared.
  4. use themes or props to stimulate discussion.
8. All of the following statements, when made by an elder client, indicate successful achievement of ego integrity except:
  1. "I think I'll volunteer at the library a couple days a week."
  2. "I wish I could change some of the things I've done."
  3. "I think I'll take a ceramic class at the senior center."
  4. "I would like to help people learn to read."

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9. At the 24-week visit, a pregnant woman demonstrates a less than expected growth in uterine size, easily palpable fetus that can be outlined by the nurse, and absence of fetal ballottement. A nurse should recognize this is most likely related to the development of:
  1. hydramnios.
  2. oligohydramnios.
  3. amniotic fluid embolism.
  4. macrosomia.
10. Which of the following clinical manifestations should the nurse document as a positive sign of pregnancy?
  1. amenorrhea
  2. uterine soufflé
  3. positive pregnancy test
  4. fetal heartbeat
11. A woman who is 20 weeks pregnant has been taught about fetal development. Which of the following statements, if made by her, indicate that she has correctly understood what has been taught?
  1. "My baby is able to breathe now."
  2. "My baby can open his eyes."
  3. "My baby's about 7 ½ inches long."
  4. "My baby's starting to grow fingernails."
12. Which of these self-care measures should a nurse suggest first for a woman in her third trimester of pregnancy who is experiencing ankle edema, leg cramps, and faintness?
  1. Practice frequent dorsi-flexion of the feet.
  2. Wear support hose.
  3. Avoid standing for long periods of time.
  4. Elevate legs when sitting.
13. The parents of a newborn have been given instructions about which toys are appropriate for their infant. Which of these statements, if made by the parents, would indicate that they correctly understood the instructions?
  1. "It will be so much fun picking out a jack-in-the-box."
  2. "I bet he'd enjoy one of those animals that squeaks when you squeeze it."
  3. "Let's get him one of those teething rings that we can put in the freezer."
  4. "We should hunt for a mirror that won't break."
14. Which of these strategies would the nurse suggest the parents add to their activities to promote tactile stimulation for an 11-month-old?
  1. Give the infant finger foods of different textures.
  2. Provide soft squeeze toys of various textures.
  3. Allow the infant to play nude on a soft, furry rug.
  4. Comb the infant's hair with a soft brush.
15. Which nursing measure should assume priority in performing a physical examination on an 8-month-old infant who is sitting contently on his mother's lap chewing on a toy?
  1. Take the toy away so that the mouth can be observed.
  2. Begin a systematic physical exam, beginning at the head and moving toward the feet.
  3. Remove all the infant's clothing so a thorough exam can be performed.
  4. Auscultate the heart and lungs and then proceed with the rest of the exam.
16. When a child demonstrates a positive Babinski sign, which age child would be most important for the nurse to follow-up?
  1. 4 months
  2. 8 months
  3. 12 months
  4. 16 months
17. Which of the following statements by a client indicates adequate understanding of post-test care after a femoral approach is used for cerebral angiography?
  1. "I cannot move my neck."
  2. "I need to keep my arm straight."
  3. "I need to keep my leg straight."
  4. "I need to wear a neck brace."
18. After receiving a client who has had a femoral approach for cerebral angiography, the nurse notices the puncture site is oozing bright red blood. Which is the most appropriate action of the nurse?
  1. Inform the physician.
  2. Monitor for changes.
  3. Document the findings.
  4. Apply pressure to the site.

- 19.** A client has had a right femoral approach for cerebral angiography. The right groin dressing is clean, dry, and intact, with no bruising or swelling at the site. The nurse notices the client's right foot has become cool, and the pedal pulse is no longer palpable, or obtained with a doppler. Which is the most appropriate action of the nurse?
1. Notify the physician.
  2. Monitor for changes.
  3. Document the findings.
  4. Apply pressure to the site.
- 20.** A client with which of the following conditions is at risk for developing a low magnesium level?
1. prostatitis
  2. lymphoma
  3. pericarditis
  4. alcoholism
- 21.** Which of the following values represents a normal pH level for an adult client?
1. 7.28
  2. 7.38
  3. 7.48
  4. 7.58
- 22.** Which of the following arterial blood gas values represents respiratory acidosis?
1. pH = 7.20 , pCO<sub>2</sub> = 50 mm Hg, HCO<sub>3</sub> = 24 mEq/L
  2. pH = 7.20, pCO<sub>2</sub> = 36 mm Hg, HCO<sub>3</sub> = 18 mEq/L
  3. pH = 7.80, pCO<sub>2</sub> = 32 mm Hg, HCO<sub>3</sub> = 32 mEq/L
  4. pH = 7.60 , pCO<sub>2</sub> = 38 mm Hg, HCO<sub>3</sub> = 30 mEq/L
- 23.** Which type of diabetes describes that which develops during pregnancy?
1. Type I
  2. Type II
  3. secondary
  4. gestational
- 24.** A client who is receiving lispro insulin (Humalog) should receive his injection from the nurse at what time?
1. 30 minutes before a meal
  2. at the time of the meal
  3. 30 minutes after a meal
  4. one hour after a meal
- 25.** Which of the following statements by a diabetic client indicates adequate understanding of foot care?
1. "I need to wash my feet in hot water."
  2. "I can go barefoot outdoors."
  3. "I need to examine my feet weekly."
  4. "I need to dry my feet thoroughly."
- 26.** The role of the nurse in rehabilitation care is to:
1. focus on interventions that improve the quality of life rather than saving life.
  2. assist the client by continuing to have the nurse tell them what to do.
  3. regulate all medications that the client is on.
  4. show concern in secondary prevention only.
- 27.** Continuous Passive Motion Devices (CMP) are:
1. machines that are used to stimulate nerve pathways all over the body.
  2. used exclusively with Cardiovascular Accident (CVA) clients.
  3. used to stimulate regeneration of articular tissues.
  4. devices for passive range of motion of arms and fingers.
- 28.** The nurse, using a CPM device for a client should:
1. adjust all areas of the device to the client's desires.
  2. adjust and align extremity, according to the client; set foot cradle at the angle ordered by the physician.
  3. set all speed dials to client's desire and needs.
  4. check on client every shift.

29. A patient tore his rotator cuff playing tennis. The normal body joint movement being affected is:
  1. abduction.
  2. adduction.
  3. internal rotation.
  4. inversion.
30. Normal mobility requires:
  1. CNS and PNS intactness and functioning musculoskeletal system and balance.
  2. CNS coordination, cerebellum balance, and muscle strength grade I/V.
  3. PNS intactness, pons balance, and muscle strength grade V/V.
  4. CNS and PNS intactness, muscle function grade V/V, bones, and cerebellum balance.
31. The best stance for a nurse to use in supporting a patient who is rising from or sitting down on the side of the bed is:
  1. feet close together.
  2. feet wide apart.
  3. pelvic tilt.
  4. standing away from the patient.
32. Which data supports a nursing diagnosis of “Risk for impairment of skin integrity”?
  1. serum albumin < 3.0, peripheral edema, signs of depression
  2. serum albumin > 4.0, slow rebound of skin, pO<sub>2</sub>=80
  3. hematocrit 39, BUN 10, slight intention tremor of hands
  4. hematocrit 32, stress incontinence, ambulatory ad lib
33. Which finding, assessed during a bedbath, indicates to the nurse that the client has poor hygiene practices?
  1. dry, flaking skin
  2. strong breath odor
  3. itchy patches on the scalp
  4. unkempt finger and toenails
34. The nurse is providing oral care for a client who is unconscious. How should the client be positioned?
  1. Sims
  2. high-Fowler’s
  3. side-lying position with the head of the bed slightly elevated
  4. semi-Fowler’s position with head turned upward
35. The teaching plan for a client who is using the basal body temperature method to plan a pregnancy should include which of these instructions?
  1. Take the temperature before going to sleep at night.
  2. Record the temperature 1–2 months before using the charts to predict ovulation.
  3. Utilize a basal body temperature thermometer or a tympanic thermometer.
  4. The rise in temperature means ovulation is about to happen.
36. When a woman is using the calendar or rhythm method of contraception, the nurse should include which of the following in the teaching plan?
  1. The fertile phase is calculated using the shortest cycle the woman has experienced.
  2. Ovulation occurs 14 days before the next period plus or minus 2 days.
  3. The woman should refrain from having intercourse the second week of her cycle.
  4. A basic assumption of the rhythm method is that the ovum is viable for 48 hours.
37. Which of these statements, if made by a client using the Billings method of birth control, would indicate that the client is at imminent risk for becoming pregnant?
  1. “My partner and I have intercourse when the cervical mucus is thick and sticky.”
  2. “My partner and I have intercourse when the cervical mucus is clear.”
  3. “My partner and I refrain from having intercourse when the cervical mucus is clear.”
  4. “My partner and I refrain from having intercourse when the cervical mucus is thick and sticky.”

- 38.** When teaching clients about the use of situational contraceptives, the nurse should include all of the following except?
1. Douching after intercourse may actually facilitate conception.
  2. Coitus interruptus requires ejaculation away from the external genitalia of the woman.
  3. Spermicides that effervesce offer the most rapid protection.
  4. Spermicides provide no protection from gonorrhea and chlamydia.
- 39.** Which medication may be given to the client with hepatic encephalopathy, in order to reduce ammonia formation?
1. Cephulac (lactulose)
  2. Lasix (furosemide)
  3. Tagamet (cimetidine)
  4. Inderal (propranolol)
- 40.** In the client with hepatic encephalopathy, which dietary component will be restricted?
1. carbohydrates
  2. protein
  3. vitamins
  4. minerals
- 41.** Which of the following is an appropriate diet for the client with acute pancreatitis?
1. regular
  2. clear liquids
  3. low cholesterol
  4. nothing by mouth
- 42.** Patients taking monoamine oxidase inhibitors (MOAI) should be educated that MOAIs interact with tyramine rich foods and beverages to cause:
1. shock.
  2. hypertensive crisis.
  3. bleeding episodes.
  4. sedation.
- 43.** Why is it often necessary to follow a complete blood count and differential when a patient is being treated with an antiepileptic drug (AED)?
1. The hematocrit is adversely affected due to increased vascular volume.
  2. AEDs affect immune modulators increasing the risk of infection.
  3. Some AEDs cause blood dyscrasias.
  4. AEDs induce fever.
- 44.** A patient of yours tells you she has asthma. Her physician has prescribed the beta blocker propranolol (Inderal). You know this medication is contraindicated in this patient because the drug will:
1. enhance the heart rate by stimulating beta 1 receptors.
  2. increase calcium influx into the myocardial cells, thus increasing contractility and myocardial oxygen consumption.
  3. antagonize beta 2 receptors.
  4. inhibit angiotensin II receptors at the angiotensin receptor blocking site.
- 45.** Your patient's blood work shows a low serum albumin level. She is receiving the anticonvulsant phenytoin (Dilantin), which is 90–95 percent protein bound. You should monitor your patient for signs of:
1. hypokalemia.
  2. CNS depression.
  3. drug toxicity.
  4. hyperalbuminemia.
- 46.** Kolcaba stresses the importance of recognizing the holistic nature of comfort. What is the best answer?
1. The nurse is responsible for the physical well-being of the client.
  2. The nurse is responsible for her competence in developing interpersonal relationships.
  3. The nurse is responsible for the ongoing integrity of the whole person.
  4. The nurse is responsible for the exercise routine of the client.

- 47.** Therapeutic touch is practiced to:
  1. help to restore an equilibrium between inward and outward energy flow.
  2. help the “yen” and “yang” to be restored.
  3. help the total body to be restored to health.
  4. help the client not to develop a blood clot.
- 48.** The major goal of cognitive-behavioral interventions are:
  1. to control the disease process.
  2. to correct all physical dysfunction.
  3. to change the client’s perception of pain.
  4. to alter the pain centers.
- 49.** A client is taking a full liquid diet following gastric surgery. The nurse evaluates the health teaching to be successful when the family brings in which of the following for the client to eat?
  1. pureed fruits
  2. custard
  3. soft cake
  4. chopped vegetables
- 50.** While doing a physical assessment on a client, the nurse suspects that the client has poor nutritional status. Which of the following would confirm the nurse’s observations?
  1. flaccid soft muscles
  2. firm, smooth pink nails
  3. moist buccal cavity mucous membranes
  4. erect posture
- 51.** The nurse evaluated the results of laboratory tests completed on a client. Which of the following values indicate an abnormality related to nutritional status?
  1. blood urea nitrogen (BUN) 15 mg/dl
  2. urinary creatinine 800 mg/24 h in the adult female
  3. Albumin 5 g/dl
  4. Serum Potassium 2.0 mEq/L
- 52.** When a patient with a terminal illness has designated a person that is responsible for making decisions about the terminal patient’s care, this is known as:
  1. living will.
  2. bill of rights.
  3. contracts duos.
  4. durable power of attorney.
- 53.** A discharge teaching plan is being implemented for a terminally ill patient for hospice. Which of the following is most appropriate to teach?
  1. The patient will go in a hospice center.
  2. Hospice is only concerned about the patient.
  3. Care occurs in the home without physician input.
  4. Focus of care is on control of symptoms and pain relief.
- 54.** A patient with breast cancer is undergoing chemotherapy. She develops myelosuppression. Her discharge teaching should include:
  1. manage sore throat with over-the-counter preparations.
  2. wear a mask when going out to shop.
  3. you can babysit ill grandchildren.
  4. avoid activities that may cause bleeding.
- 55.** The RN notes a nonblanchable erythema over a bony prominence that does not disappear after the patient is turned. The nurse knows this is a:
  1. Stage I pressure ulcer.
  2. Stage II pressure ulcer.
  3. Stage III pressure ulcer.
  4. Stage IV pressure ulcer.
- 56.** The RN is caring for an overweight patient who has been treated with long-term oral steroids. Assessment of the skin reveals moist red areas with a white scale fringe in the skin folds. The nurse suspects:
  1. tinea corporis.
  2. tinea pedis.
  3. impetigo.
  4. candidiasis.

- 57.** The care for a patient with venous stasis ulcers includes:
1. compression, elevation, and skin care.
  2. compression, elevation, and low-fat diet.
  3. no compression, keep legs lower than heart, and skin care.
  4. no compression, keep legs lower than heart, and low-fat diet.
- 58.** The most important risk factors associated with the development of pressure ulcers are:
1. immobility, confusion, and obesity.
  2. immobility, malnutrition, and incontinence.
  3. malnutrition, incontinence, and obesity.
  4. incontinence, obesity, and hypothermia.
- 59.** After group therapy, the female victim of intimate partner violence confides in the nurse that she does not feel in any immediate danger. Which of the following facts suggests to the nurse that this statement is correct?
1. Victims of domestic violence are often the best predictors of their risk of harm.
  2. Victims of domestic violence often overestimate their safety risk.
  3. Victims of domestic violence are typically in a state of denial.
  4. Victims of domestic violence know that keeping peace with their partner is the best method of preventing another attack.
- 60.** A 32-year-old female frequently comes to her primary care provider with vague complaints of headache, abdominal pain, and trouble sleeping. In the past, the MD has dutifully prescribed medication, but little else. Which of the following statements by the nurse to the MD are correct?
1. "Often women who are victims of domestic violence suffer vague symptoms such as abdominal pain."
  2. "Often women will become offended if asked about their safety in relationships."
  3. "It is mandatory that all women are questioned about domestic violence."
  4. "How would you feel to know that her partner is beating her, and you didn't ask?"
- 61.** Racial bias is present in mental health services as reflected by:
1. it is increasingly difficult to receive reimbursement for services.
  2. inadequate medication for non-white clients treated as inpatients.
  3. white clients are given access to better facilities in treatment centers.
  4. few mental health care providers are from minority cultures.
- 62.** A nurse is providing an inservice program about culture and mental disorders. Which fact would be included?
1. Substance abuse is more prevalent in women than men.
  2. Depression and anxiety disorders are more prevalent in women.
  3. African Americans are more likely to seek help for mental disorders than whites.
  4. The rate of mental illness is similar in all cultures.
- 63.** A three year old is brought to the emergency room for vaginal discharge. Upon assessment, the nurse notes the child is cooperative, uninhibited with the exam, presents with enlarged vaginal and rectal orifices, multiple bruising of the perineum and has purulent yellow discharge on her panties. Further inspection reveals multiple scratches and bruises in various stages of healing and unusual round open lesions that are suspicious for cigarette burns. The doctor diagnoses urinary tract infection and orders an antibiotic. The nurse should:
1. Call another physician to examine the child.
  2. Document the findings, inform the physician, and report the incident to authorities.
  3. Call security personnel and have the child removed from the caregiver immediately.
  4. Confront the caregiver and have her/him arrested.
- 64.** The nurse assesses for which of the following mental disorders in a child who has experienced abuse?
1. schizophrenia
  2. bipolar disorder
  3. paranoia
  4. post-traumatic stress disorder

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- 65.** When assessing a client who has the most adaptive sexual responses, a nurse should expect to obtain which of these findings?
1. satisfying sexual behavior that respects the rights of others
  2. sexual behavior impaired by anxiety resulting from personal or societal judgment
  3. dysfunction in sexual performance
  4. sexual behavior that is harmful, forceful, nonprivate, or not between consenting adults
- 66.** Which of the following phases represents the nurse's first step in developing self-awareness and clarification of values regarding human sexuality?
1. anxiety
  2. anger
  3. cognitive dissonance
  4. action
- 67.** When a client says to the nurse, "I don't feel like a man; I feel like a woman inside a man's body, and as a woman I am attracted to men," the nurse should recognize this as indicative of:
1. bisexuality.
  2. transvestism.
  3. transsexualism.
  4. homosexuality.
- 68.** When a male client has premature or retarded ejaculation, which of the stages of the sexual response cycle is disrupted?
1. desire
  2. excitement
  3. orgasm
  4. resolution
- 69.** When assessing a male client's sexual genetic identity, using the biological factors, a nurse should expect to obtain which of these findings?
1. XX chromosomes
  2. XY chromosomes
  3. XXY chromosomes
  4. XXX chromosomes
- 70.** Which of the following behaviors are most likely associated with a 9-year-old child whose parents have divorced?
1. increased aggression
  2. somatic complaints
  3. extreme sadness
  4. anger
- 71.** Which of the following essential features would the nurse expect to identify in a family experiencing partner relational problems?
1. over protection or inadequate discipline
  2. negative or distorted communication
  3. development of symptoms in siblings
  4. difficulty with others, such as co-workers
- 72.** Which of these characteristics would be most significant when assessing a family for structure?
1. process of resolving differences of opinion
  2. consideration of alternative lines of action
  3. amount and clarity of information exchange
  4. leadership and distribution of function
- 73.** When completing a family APGAR, the nurse would assess the degree of satisfaction in all the following categories except?
1. shared resources
  2. communication and problem solving
  3. social support systems
  4. emotional interaction
- 74.** When assessing a client from a functional family, a nurse should expect to identify which of the following characteristics?
1. Children are responsible for activities advanced for their age.
  2. Differences between family members are discouraged.
  3. Emotional contact is maintained across generations.
  4. Commonly use a third party to resolve problems.
- 75.** Which of the following nursing diagnoses is most appropriate for a client in Buck's traction?
1. imbalanced nutrition
  2. decreased cardiac output
  3. risk for impaired skin integrity
  4. impaired communication



- 76.** A client with a fractured wrist has a plaster cast placed on it in the emergency room. Which of the following statements by a client indicates adequate self-care?
1. "If my wrist itches, I'll put a coat hanger inside to scratch it."
  2. "I'll take a short shower while I have the cast."
  3. "I will report swelling of my hand to the doctor."
  4. "If the cast breaks, I'll wrap tape around it."
- 77.** Which of the following is *not* a complication of fractures?
1. infection
  2. Brown-Séquard syndrome
  3. compartment syndrome
  4. fat embolism
- 78.** A client with a total hip replacement is preparing to go home from the rehabilitation center. Which of the following statements by a client indicates a need for further teaching by the nurse?
1. "I will cross my legs when I sit in a chair."
  2. "I will use a toilet elevator on my toilet."
  3. "I will notify my surgeon of any severe pain."
  4. "I will keep my hip in a neutral, straight position."
- 79.** At work, several long-term clients have recently died. Which of the following actions is most likely to represent ineffective coping?
1. The nurse talks at length to her partner about the deaths.
  2. The nurse keeps busy with other actions and doesn't think about the deaths for several days.
  3. The nurse offers to work extra shifts for several weeks.
  4. Several nurses schedule a group sessions with agency clergy to discuss the deaths.
- 80.** The nurse wishes to help a 50-year-old client identify previously successful coping strategies that may be useful in the current situation of needing to begin taking insulin for diabetes. Which of the following most likely represents a stressor of a similar style to the current one?
1. interviewing for a new job
  2. death of a pet while the person was a teenager
  3. the person's partner filing for a divorce
  4. starting to wear eyeglasses at age 30
- 81.** Developmental stressors that can increase anxiety in the middle-aged are:
1. menopause, climactic, aging
  2. retirement, alcoholism, drug addiction
  3. menopause, birth, alcoholism
  4. aging, birth, obesity
- 82.** The nurse's role in health promotion regarding mental health is:
1. to foster support to the client and family in helping them to learn from their experiences and renew efforts to change.
  2. to help solve problems and make decisions for the client and family.
  3. to increase the lifestyle changes necessary for the client to live longer.
  4. to help the client modify behavior and change all environmental causes.
- 83.** Which of the following statements is correct concerning drug tolerance?
1. Tolerance occurs because of physiological dependence on the drug.
  2. Tolerance is the requirement of increased amounts of a substance to achieve effects previously obtained with a smaller amount.
  3. Tolerance is the excessive use of a substance to achieve pain or relaxation.
  4. Tolerance is manifested by physical signs and symptoms of withdrawal when the substance is not taken.

- 84.** The compulsive need for a drug with or without tolerance and/or withdrawal signs or symptoms and despite negative social implications with its continued use is:
1. addiction.
  2. intolerance.
  3. psychological dependency.
  4. delirium tremens.
- 85.** Which blood type is known as the universal donor?
1. A
  2. B
  3. AB
  4. O
- 86.** Which blood type is known as the universal recipient?
1. A
  2. B
  3. AB
  4. O
- 87.** A client that was started on a transfusion of packed red blood cells begins to complain of chest tightness, anxiety, and shortness of breath. What should the nurse do first?
1. Monitor the client.
  2. Check the vital signs.
  3. Check the oxygen saturation.
  4. Stop the transfusion.
- 88.** An elderly client admitted for dehydration and electrolyte imbalance states “Get these bugs off of me.” The nurse would respond:
1. “There are no bugs here. You are imagining them.”
  2. “I’ll just brush them away for you.”
  3. “I do not see any bugs.”
  4. “Your electrolyte imbalance is making you feel this way.”
- 89.** A client with a diagnosis of antisocial personality disorder is manipulating the other clients into arguing and fighting. Previous attempts to help the client control this behavior have resulted in the client becoming angry and arguing with staff. The nurse’s best response at this time would be:
1. “I can’t understand why you are putting the team in a position to reassess your stay. Has there been a change in wanting to help yourself?”
  2. “We cannot allow you to keep harassing the other residents. If you continue to behave this way, you will be transferred to another facility.”
  3. “Since you cannot control your behavior, I will ask the doctor for a stronger medicine to help you control your behavior.”
  4. “I have told you to stop this behavior. Since you continue to incite the other residents, you will lose your privilege to go to the canteen.”
- 90.** A woman who had been sexually abused as a child reports, “I feel like it just happened yesterday.” To determine the precipitating event for the returned feelings, the nurse’s best response would be:
1. “That is irrational, it happened a long time ago.”
  2. “Tell me what happened the day before you started feeling like this.”
  3. “You should have resolved these feelings by now.”
  4. “It must be frightening to feel unprotected.”
- 91.** The physical examination and evidence collection is completed on a sexual assault victim. The victim is sitting motionless and appears dazed and unaware of the surroundings. The nurse would interpret the behavior as:
1. normal behavior following a traumatic event.
  2. indications of a severe mental disorder.
  3. signaling the need for suicide precautions.
  4. signs that the person should be hospitalized.
- 92.** A patient with Hepatitis B is being discharged in 3 days. What should the nurse include in the discharge planning?
1. Eat large meals three times a day.
  2. Avoid alcohol for 1 week.
  3. Family members do not need to receive an immunoglobulin shot.
  4. Use a condom during sexual intercourse.

- 93.** Most states require the administration of erythromycin (0.5 percent) or silver nitrate into the eyes of newborns to prevent which sexually transmitted disease?
1. HIV or AIDS
  2. herpes
  3. syphilis
  4. gonorrhea
- 94.** An example of a disease prevention program would be which of the following?
1. prostate exam clinic
  2. breast exam clinic
  3. immunization clinic
  4. all of the above
- 95.** Percussion of body tissue makes sounds that are:
1. soft over fluid.
  2. loud over air.
  3. dull over lungs.
  4. flat over gastric bubble.
- 96.** The physician and the nurse take a health history from the client. Which factor does the nursing health history assess that the medical one does not?
1. family health history
  2. status of body systems
  3. impact of illness on the client and family
  4. current health status
- 97.** While taking the client's history, the nurse develops a genogram. What is the purpose of the genogram?
1. to identify potential or undetected physiological disorders
  2. to identify genetic and familial health problems
  3. to identify the chief complaint
  4. to identify chronic disorders
- 98.** A living will addresses:
1. a client's wishes regarding fluid and hydration treatment.
  2. place of burial.
  3. financial disbursements upon death.
  4. disbursement of personal property.
- 99.** Nursing advocacy is:
1. making decisions for patients.
  2. encouraging patients to follow all doctor's orders.
  3. encouraging and supporting patient decisions concerning rights and healthcare choices.
  4. completion of all forms for patients.
- 100.** Coordination of care in case management includes all of the following except:
1. organizing resources for use by the patient.
  2. choosing a treatment option for a patient due to proximity to the patient's home.
  3. securing resources for in-home therapy based upon the patient's preference.
  4. integrating patient chosen options for care into the medical treatment plan.
- 101.** When teaching a class of middle school girls about safety precautions to prevent rape, the nurse will emphasize which of the following?
1. A person that rapes is generally seriously mentally ill.
  2. The incidence of violence against women is greater in minorities.
  3. Rape is about power and anger.
  4. There is very little risk of a sexually transmitted disease during a rape.
- 102.** A test with the ability to identify correctly those who have the disease is considered:
1. specific.
  2. sensitive.
  3. invalid unless approved by the FDA.
  4. Such a test does not exist as most tests are based on extrapolated data.
- 103.** The main purpose of rubella titer prenatal testing is:
1. to determine the correct dose of MMR.
  2. to screen the population aggregate for history of rubella infection.
  3. to offer primary prevention against congenital rubella syndrome.
  4. to determine fetal antibodies.

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**104.** A school-age child is diagnosed with impetigo. The nurse will teach:

1. frequent salt water gargles.
2. a diet high in fatty foods.
3. contact isolation.
4. use of eye protection.

**105.** Which of the following was developed by the American Hospital Association to define the rights and responsibilities of patients in the acute care setting?

1. Code of Ethics
2. Hospital Advocacy
3. Patient Bill of Rights
4. OBRA Regulations

**106.** You meet your new nurse manager for the first time. She makes eye contact, smiles, initiates a conversation about your previous work experience, and encourages your active participation in the dialogue. Her behavior is an example of:

1. aggressiveness.
2. passive-aggressiveness.
3. passiveness.
4. assertiveness.

**107.** Confidentiality is:

1. a right of only competent patients.
2. a right which encompasses only the patient-physician relationship.
3. a right of the patient to assume that information given to a healthcare provider will not be disclosed.
4. a right that applies only to verbal information.

**108.** Your patient has suffered a CVA that has left her with aphasia. The most appropriate member of the interdisciplinary healthcare team to be consulted would be:

1. physical therapist.
2. social worker.
3. speech therapist.
4. diabetic nurse educator.

**109.** An individual's health beliefs and practices are influenced by all of the following internal variables *except*:

1. developmental stage.
2. intellectual background.
3. family practices.
4. emotional and spiritual factors.

**110.** An elderly client admitted for a chief complaint of acute confusion receives an RPR and treponema pallidum studies. Correlated with the client's altered mental state, positive findings demonstrate an etiology of what infectious process?

1. neurosyphilis
2. community acquired pneumonia
3. streptococcal meningitis
4. staphylococcus septicemia

**111.** If the client is not allergic, what medication is the drug of choice for chlamydia?

1. Ceftriaxone
2. Metronidazole
3. Amoxicillin
4. Azithromycin

**112.** If the client is not allergic, what medication is the drug of choice for strep pharyngitis?

1. Penicillin
2. Tetracycline
3. Metronidazole
4. Acyclovir

**113.** The nurse, when using restraints, must:

1. call a nurse "tech" to sit with the client.
2. ensure safety and infection control.
3. ensure safety and document.
4. be sure visitor or relative is with the client all the time.

**114.** Restrained clients often display \_\_\_\_\_ behavior.

1. restless and anxious
2. quietness and in-control
3. comfortable and restful
4. obedient and calm

- 115.** What are restraints?
1. binding of the body
  2. protective devices to limit physical activity
  3. mobility devices that have straps
  4. confinement devices for the bed
- 116.** Common causes of hyperkalemia include the following except:
1. renal insufficiency.
  2. administration of IV solutions with large doses of potassium chloride in each solution.
  3. potassium-wasting diuretics.
  4. poor urine output for days.
- 117.** A client's serum potassium level is 6.1 mEq/L. The nurse should observe for signs and symptoms of hyperkalemia, which include the following except:
1. abdominal cramps.
  2. muscular weakness.
  3. tachycardia and later bradycardia.
  4. oliguria.
- 118.** Drugs commonly used to treat hyperkalemia include the following except:
1. Glucagon.
  2. IV sodium bicarbonate, calcium gluconate.
  3. insulin and glucose.
  4. Kayexalate and sorbitol.
- 119.** A client, 68 years old, has a calcium deficit. Her serum calcium level is 3.6mEq/L. The client's serum calcium level is:
1. slightly low.
  2. severely low.
  3. low average.
  4. normal.
- 120.** The nurse writes, "Knowledge deficit regarding prevention of crisis" on the nursing care plan of a client, an 18-year-old male with sickle cell anemia. After a client has been taught to avoid situations that can precipitate a crisis, which of the following actions would indicate a need for follow-up education?
1. applying for a driver's permit
  2. planning a vacation at a beach resort
  3. staying up until 3:00 A.M. to study for a test
  4. applying antiseptic to a cut on his finger
- 121.** In a patient suspected of having aplastic anemia, the nurse should plan to:
1. take a thorough history of medication and chemical exposures.
  2. assess for renal disease and administer prescribed folic acid.
  3. teach the patient which foods have a high iron content and administer prescribed iron.
  4. assess the patient for signs of infection and administer ordered prophylactic antibiotics.
- 122.** Which of the following observations reported by a patient with acute myelogenous leukemia (AML) would the nurse first assess?
1. weakness and fatigue
  2. bruising on the arm
  3. drainage from a small finger cut
  4. mild abdominal pain
- 123.** The nurse has reviewed a discharge teaching checklist for a client, a 65-year-old male with chronic lymphocytic leukemia (CLL). Which of the following statements by the client would indicate to the nurse that further review is necessary?
1. "I'm retired, so I can sleep whenever I want."
  2. "I've got season tickets for all the basketball games."
  3. "I'll call the doctor if I have fever greater than 99°F."
  4. "I'm going to teach my grandson how to fish."
- 124.** Mr. Gordon, aged 80, has come to a health maintenance organization for an annual physical examination during a regional flu epidemic. The nurse's evaluation that Mr. Gordon's preventive measures to protect himself against the illness are appropriate would be based on which of the following behaviors?
1. He covers his nose and mouth with a handkerchief when he sneezes or coughs.
  2. He takes prophylactic antibiotics.
  3. He receives the appropriate flu vaccine each year.
  4. He asks to have a throat culture done to detect infection.

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- 125.** While on a trip to a malarious tropical region, the nurse determines that her traveling companion is at risk for malaria because she:
1. takes prophylactic chloroquine.
  2. wears long-sleeved shirts and pants.
  3. seems to nap often.
  4. takes frequent evening walks.
- 126.** Ms. Roberts, a 23-year-old single mother of two young children, comes sporadically to the infectious disease clinic for follow-up treatment of tuberculosis. The nurse knows that she is on antidepressive medication because last week at the clinic she dropped her pills, and the nurse happened to pick them up. To ensure proper treatment and follow-up, all the following interventions would be appropriate *except*:
1. arrange to have Ms. Roberts meet with the social worker to discuss insurance benefits.
  2. schedule Ms. Roberts' appointments during her lunch break from work.
  3. tell Ms. Roberts that you understand how hard it is to comply with treatment when she is feeling blue.
  4. keep crayons and paper in the waiting room so that her children can occupy themselves while they wait.
- 127.** Cellular derangements that occur in shock and lead to pathophysiologic alterations include:
1. increased cellular permeability.
  2. aerobic metabolism of glucose.
  3. increased activity of the sodium-potassium pump.
  4. an alkalotic intracellular environment.
- 128.** Which of the following terms is used to describe minor injuries or illnesses requiring first-aid level of management?
1. triage
  2. urgent
  3. emergent
  4. immediate
- 129.** When field triage has occurred and the patient is admitted to the ED with a yellow tag, the ED nurse recognizes that the tag indicates that the patient requires which type of care?
1. emergent
  2. immediate
  3. urgent
  4. psychological support
- 130.** When the patient arrives at the emergency room and is unconscious, which of the following actions by the nurse is most important regarding obtaining consent to examine and treat?
1. Ask the physician to sign the consent form.
  2. Contact the nearest relative.
  3. Seek a court order for treatment.
  4. Document the patient's critical status in his or her medical record.
- 131.** The physician orders 25 milligrams of diphenhydramine hydrochloride (Benadryl) prior to a blood transfusion for a patient. The nurse knows this product is often given prior to a blood transfusion because:
1. it decreases the chance of an allergic reaction to the blood.
  2. it will make the patient drowsy, and he will sleep during the blood transfusion.
  3. it will prevent sneezing and accidental dislodgement of the IV.
  4. it will prevent the transmission of hepatitis.
- 132.** Which of the following patients may require platelet transfusions?
1. a patient who underwent chemotherapy two years ago
  2. a bone marrow donor
  3. a patient with an artificial heart valve
  4. a patient with congenital heart disease
- 133.** A central venous access device (CVAD) will not flush because of a clot. The physician will likely order instillation of which product into the catheter to restore patency?
1. a fibrinolytic agent
  2. heparin sodium
  3. protamine sulfate
  4. an acidic solution containing H<sup>+</sup> ions

- 134.** What type of patient monitoring can be accomplished by a central venous access device such as a subclavian vein catheter?
1. arterial blood pressure (ABP)
  2. central venous pressure (CVP)
  3. left ventricular end diastolic pressure (LVEDP)
  4. cardiac output (CO)
- 135.** Antimetabolites used for cancer treatment work by:
1. enhancing cell growth.
  2. bone marrow ablation.
  3. inhibiting cell growth and proliferation.
  4. limiting the ability of the cancer to metastasize.
- 136.** The synthetic cannabis derivative dronabinol (Marinol) can be used to treat cancer patients for:
1. depression.
  2. nausea.
  3. pain.
  4. mucositis.
- 137.** Aspirin may be effective in the treatment of myocardial infarction (MI) because it reduces:
1. fever.
  2. inflammation.
  3. platelet aggregation.
  4. chest pain.
- 138.** The nonsteroidal anti-inflammatory drugs (NSAIDs) are beneficial in treating arthritis because they:
1. are considerably cheaper than steroids.
  2. mediate the inflammatory response.
  3. have relatively few side effects and are well tolerated.
  4. are available over-the-counter.
- 139.** When administering an IV medication into a medication port on IV tubing, the nurse must select the proper gauge of needle. Gauge is:
1. the length of the needle.
  2. the diameter of the syringe barrel.
  3. the area where the needle attaches to the syringe.
  4. the inner diameter of the needle.
- 140.** The physician orders a liter of normal saline IV for a patient. It should infuse over four hours. The nurse will set the infusion pump rate:
1. at 250 milliliters per hour.
  2. after asking the physician at what rate it should run.
  3. at a rate that is comfortable for the patient.
  4. at the rate suggested by the pharmacy.
- 141.** A patient asks a nurse what's the definition of total parenteral nutrition (TPN). The nurse responds by saying:
1. "It is a convenient method of providing nutrition."
  2. "TPN is part of long-term patient care."
  3. "An IV solution that provides adequate nutrition."
  4. "An inexpensive way to give protein and vitamins."
- 142.** How can total parenteral nutrition (TPN) be of primary value in a patient receiving chemotherapy who has stomatitis and severe diarrhea?
1. TPN will prevent nosocomial infections.
  2. It will prevent dehydration.
  3. These symptoms will resolve if the patient does not take oral nutrition.
  4. It will provide nutrition.
- 143.** Which of the following methods of drug administration is the most expensive parenteral route?
1. intravenous
  2. subcutaneous
  3. intramuscular
  4. intradermal
- 144.** In adults, the preferred site of administration of most injections is the:
1. deltoid muscle.
  2. gluteus maximus.
  3. anterolateral thigh.
  4. abdomen.

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- 145.** The type of sleep that composes most of the sleep during a night is \_\_\_\_\_ sleep.
1. REM
  2. NREM
  3. physiologic
  4. synchronized
- 146.** The stage of sleep in which a person feels drowsy or relaxed, and the eyes roll from side to side is known as:
1. REM stage 1
  2. non-REM stage 1
  3. non-REM stage 4
  4. REM stage 4
- 147.** Which of the following stages of NREM sleep is thought to restore the body physically?
1. REM
  2. NREM II
  3. NREM III
  4. NREM IV
- 148.** The JCAHO defines quality improvement as:
1. the retrospective identifications of problems.
  2. the continuous study and improvement of the processes of providing healthcare.
  3. focused on facility outcomes.
  4. activities done on a quarterly basis.
- 149.** In the last 2–3 decades the nursing profession has dealt with shortages in the supply of nurses. Effective delegation has become a vital nursing skill as it is imperative to:
1. ensure quality patient care.
  2. utilize available staff appropriately.
  3. promote cost effectiveness.
  4. all of the above.
- 150.** Occasionally in a healthcare facility an older adult patient may become confused and begin to wander. The advantage for using a sensor and alarm system for such patients is that they:
1. allow patients the freedom of mobility without fear of getting lost.
  2. minimize the direct supervision needs of the patient.
  3. increase the need for restraints.
  4. alert the patient that they are doing something that they shouldn't.
- 151.** All of the following factors may affect a supervisor's relationship with those being supervised except:
1. personal style.
  2. other relatives working within the facility.
  3. the ability and experience of the supervisee.
  4. the physical distance.
- 152.** Crisis intervention theory is based on which assumptions?
1. Crises lead to long-term damage.
  2. A crisis is abnormal and requires long term therapy.
  3. Crises are resolved within six weeks.
  4. Crises are signs of deep psychological problems.
- 153.** A client goes to the local mental health center due to increased feelings of anxiety. The nurse suspects the client has a situational crisis due to the recent death of her mother. The nurse would:
1. ask the client to talk about how her mother's death affect her.
  2. avoid discussing the mother's death because this will increase the client's feelings of loss.
  3. inform the client that the feelings of loss will decrease over time.
  4. instruct the client to not think about the loss of her mother.
- 154.** During assessment, which question would be best as a general screening tool for elder abuse?
1. "Are you happy?"
  2. "Does anyone at home make you afraid or uncomfortable?"
  3. "Do you know someone you can go to in a crisis?"
  4. "Have you ever been left alone for long periods of time?"
- 155.** A nurse suspects elder abuse, but is reluctant to report it because she is not sure the abuse actually occurred. What are the results of a nurse reporting suspected elder abuse that is later found to not have occurred?
1. The nurse can be prosecuted for slander.
  2. The nurse could be held liable for false statements.
  3. The nurse could lose her license.
  4. The nurse is protected from liability.



- 156.** Family members bring a client diagnosed with bipolar disorder to the mental health clinic. The family reports the client is not eating or drinking and is disrupting the household. The client states, "My family would be better off without me." The nurse and family discuss the situation and determine that the best plan is to:
1. obtain a blood sample to determine whether the medication levels are therapeutic.
  2. place the client in an acute care psychiatric hospital.
  3. have family members provide continuous observation of the client.
  4. have the client attend the day-care program while the family is at work.
- 157.** A client is diagnosed with generalized anxiety disorder. The client is unable to shop, take care of the children, or manage the household. The client will eat whatever the husband provides. The client remains in bed most of the time. The husband asks, "How long will my wife have to be hospitalized?" The nurse's best response would be:
1. "Since your wife can take care of her basic needs and is not a threat to herself or the children, she will not require hospitalization."
  2. "Your wife will need to remain in the hospital until the blood levels of her medication are at a therapeutic level."
  3. "We will put your wife in our day-care program, and she can spend the nights at home where you can watch her."
  4. "Instead of hospitalization, it would be best to place your wife in residential care where she can feel secure."
- 158.** For professional nurses, Maslow's hierarchy provides a theoretical foundation for establishing priorities. According to Maslow's theory, which of the following has the highest priority?
1. the need to be loved by someone
  2. the need for physical safety and security
  3. the need for nebulizer treatments to alleviate dyspnea
  4. the need to know that as a nurse you've done your best
- 159.** The first step in the ethical decision-making process is to:
1. consider the alternatives.
  2. collect, analyze, and interpret data.
  3. consider the consequences of the actions.
  4. make a decision.
- 160.** Ms. Blackburn brings her daughter, Becky, age 4, in for her annual check-up. The nurse plots Becky's height and weight on a pediatric growth grid. Normal growth is represented by which range of percentage?
1. 50–100th percentile
  2. 25–75th percentile
  3. 10–100th percentile
  4. 5–95th percentile
- 161.** The nurse should use which assessment tool to evaluate Mr. Greenspan's nutritional patterns?
1. anthropometric measurements
  2. height and weight measurements
  3. 24-hour diet recall
  4. lipid profile
- 162.** Vitamins are essential for:
1. transmission.
  2. psychosocial.
  3. catabolism.
  4. metabolism.
- 163.** \_\_\_\_\_ influences health and illness, thus health promotion.
1. Culture
  2. Men
  3. Women
  4. Chiropractor
- 164.** A major factor of Pender's Health Promotion Model states:
1. stimulus controls all behavior.
  2. behavior cues are important factors in promoting health behavior change.
  3. the nurse can change factors to promote behavior change.
  4. the environment controls all health beliefs.

- 165.** Behavior cues in Pender's Health Promotion Model, for nurses to identify and offer instruction, may be taken from a variety of sources. The major sources are:
1. contact with foreign people.
  2. arrangements attracted by others.
  3. communication media.
  4. depressive situations.
- 166.** A 40-year-old female client asks the nurse when her first mammogram should be conducted. The nurse's best response is which of the following?
1. The recommendation is that women over age 30 receive annual mammogram screenings.
  2. The recommendation is that women begin annual mammogram screening at age 40.
  3. The recommendation is that women begin annual mammogram screening if they find a lump via breast self exam.
  4. The recommendation is that women begin annual mammogram screening at age 40 if there is a family history of breast disease.
- 167.** A client is being scheduled for her first mammogram. It is important for the nurse to tell the client which of the following?
1. The procedure will take approximately one hour.
  2. Do not apply deodorant, cream, or powder to breast, nipple or underarm on examination day.
  3. The exam will not result in any discomfort.
  4. The procedure uses ultrasound technology.
- 168.** A 45-year-old client is scheduled for a mammogram. Her daughter, age 20, is with her and asks why younger women are not routinely screened for breast cancer by mammogram. The nurse's best response is which of the following?
1. Younger women are not at risk for breast cancer.
  2. Younger women tend not to follow routine recommendations.
  3. Younger women are routinely screened for breast cancer in other ways.
  4. Younger women have dense breast tissue.
- 169.** The nurse says to the client, "I'm here to help you." The client states, "I don't want to talk," and turns away from the nurse. Basing your answer on knowledge about the structural model of communication, which of the following statements about the situation is correct?
1. No feedback loop exists because the client did not respond.
  2. The client's verbal and nonverbal behavior constitutes a feedback loop.
  3. The nurse's message is the feedback loop.
  4. A feedback loop is not illustrated in the situation.
- 170.** During an interaction with the nurse, a client with bipolar disease states that she doesn't have anything to contribute to the art therapy group. Upon exploration of the client's concerns, the nurse recognized the client's pattern of withdrawal and nonparticipation in situations requiring communication with others. Which nursing diagnosis would be appropriate for this client?
1. impaired social interaction
  2. impaired trusting relationship
  3. impaired nurse-client relationship
  4. impaired personal/artistic feelings
- 171.** A client confides to the nurse that his mother remarried two months following the death of his father. Which of the following outcome criteria would be most appropriate for the client?
1. Express emotions to his mother freely.
  2. Accept the marriage without causing added stress to the relationship.
  3. Avoid revealing his feelings to his mother.
  4. Have a friend discuss his feelings with his mother.
- 172.** The nurse evaluates the outcome criteria of a dying client and discerns that the goal has not been met. Which of the following should the nurse do first?
1. Talk with the client's family to determine whether they have intervened inappropriately.
  2. Notify the physician immediately.
  3. Reassess to determine whether the nursing diagnosis was appropriate.
  4. Ask that another nurse take over care of the client.

**173.** Symptoms of cholelithiasis include all of the following except:

1. nausea and vomiting.
2. right upper quadrant tenderness.
3. decreased serum bilirubin levels.
4. abdominal distress.

**174.** Short-term starvation involves:

1. glycogenolysis.
2. gluconeogenesis.
3. proteolysis.
4. Both 1 and 2 are correct.

**175.** Which type of jaundice is due to increased destruction of erythrocytes?

1. obstructive
2. hemolytic
3. hepatocellular
4. Both 2 and 3 are correct.

**176.** When assessing a patient admitted with a bleeding gastric ulcer, the nurse should expect to find which of the following stool characteristics?

1. coffee-ground color
2. clay colored
3. black, tarry
4. bright red

**177.** Which statement is incorrect regarding lung cancer?

1. The 5-year survival rate depends on tumor histology and disease stage at the time treatment is initiated.
2. Small-cell lung cancer has an excellent prognosis.
3. The 5-year survival rate for lung cancer is less than 15 percent.
4. Lung cancer is usually widespread by the time it is detected on chest x-ray.

**178.** A client is scheduled for external radiation treatment for laryngeal cancer. Of the following, which is *not* a common systemic side effect of this treatment?

1. nausea
2. fatigue
3. malaise
4. dry desquamation of the skin

**179.** When teaching the client about upcoming external radiation treatments, the nurse should stress the importance of:

1. massaging the area daily.
2. exposing the area to sunlight for 30 minutes each day.
3. not using soap on the treatment area and ink markings.
4. applying cosmetic creams over the area to conceal reddened areas.

**180.** All of the following information should be included when filling out an incident report except:

1. a statement of the nurse's observations.
2. an appropriate patient assessment.
3. a statement of the nurse's actions upon discovery.
4. the nurse's interpretation of what likely caused the incident.

**181.** When witnessing the client's signature on consent for a procedure, the nurse verifies that the consent was obtained in an appropriate manner. In doing so, he or she is verifying that:

1. there was adequate explanation of information.
2. there was sufficient comprehension of information.
3. there was voluntary consent on the client's part.
4. the client has full awareness of the post procedure recovery.

**182.** OBRA (Omnibus Budget Reconciliation Act of 1987) was important legislation responsible for changing nursing home care and operations. Needs for the law stemmed from:

1. centralized control of nursing homes.
2. reports of poor care quality and abuse of nursing home residents.
3. funding problems.
4. decreasing number of older adults requiring long-term care.

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**183.** Organ donation is the donation of specific tissues or organs:

1. from deceased donors only.
2. from neither living or deceased donors.
3. from living donors only.
4. from either living or deceased donors.

**184.** An IV fluid of dextrose 5 percent in water (D5W) contains how many grams of dextrose in a liter bag?

1. 5 grams
2. 50 grams
3. 200 grams
4. 500 grams

**185.** A physician orders a patient's IV fluids to run through a peripheral IV. A very common site for peripheral IVs in an adult is:

1. the femoral vein.
2. the saphenous vein.
3. the basilic or cephalic vein.
4. a scalp vein.

**186.** Prostaglandins enhance inflammation. In arthritis therapy, drugs that block prostaglandin production are beneficial. These medications affect what enzyme responsible for prostaglandin production?

1. arachidonic acid
2. sterol
3. thromboxanes
4. cyclooxygenase

**187.** Biotransformation is also known as:

1. absorption.
2. distribution.
3. metabolism.
4. elimination.

**188.** A patient with congestive heart failure (CHF) is taking a daily diuretic. His condition has changed from Class I (ordinary activity does not cause undue dyspnea or fatigue) to Class II (ordinary activity causes dyspnea or fatigue). He is a good candidate for additional drug therapy including:

1. digitalis glycosides.
2. sodium and water restriction.
3. antiarrhythmics.
4. daily aspirin.

**189.** High alert drugs:

1. are expensive in most cases.
2. are the most effective medications available.
3. are frequently lethal if given incorrectly.
4. should be considered for pediatric patients.

**190.** When learning of the diagnosis of deep vein thrombosis, a client states that "If it is God's will, I will get better." Which of the following would be the highest priority intervention in order to provide culturally competent care?

1. Notify the physician immediately.
2. Convey respect for the client's belief.
3. Further assess the client's knowledge of the disease.
4. Introduce yourself with your title.

**191.** A Jewish client confesses to the nurse that he fears he will never walk again following back surgery. He feels his lack of health stems from punishment for past sin. What goal has the highest priority for this client?

1. Restore spiritual well-being.
2. Enhance relationships with support people.
3. Walk within three days of surgery to facilitate coping.
4. Pray the rosary for forgiveness.

**192.** Which of the following cells produce myelin, which permits rapid nerve conduction?

1. Ependyma
2. Microglia
3. Oligodendroglia
4. Astrocyte

**193.** The ability to sit upright in a chair is due in part to which of the following type of sensory reception?

1. tactile process
2. kinesthetic process
3. tactile nerves
4. visceral process

**194.** Crises events are best described as:

1. crises precipitated by multiple events.
2. crises for one person will be a crisis for the next person.
3. crises are a chronic state of coping.
4. crises are short-lasting, being resolved in approximately 6 weeks.

- 195.** When a husband takes out his work frustrations/anger by abusing his wife at home, the nurse would identify this crisis as which type?
1. psychiatric emergency crisis
  2. developmental crisis
  3. anticipated life transition
  4. dispositional crisis
- 196.** Joan had been under a great deal of stress at work. She worked long hours to make up for a staff shortage. When she went home, she propped her feet up in front of the TV and ate until she went to bed. She felt too exhausted to exercise. She gained 25 pounds in a month. At five feet tall, she weighs 175 pounds. What is a possible etiology of Joan's obesity?
1. developmental obesity
  2. obesity related to an underlying medical condition
  3. reactive obesity
  4. side effects of pharmacotherapy
- 197.** One of the goals for Joan is to help her replace compulsive eating by recognizing the anxiety that precedes bingeing and reducing it via a constructive strategy. Of the following interventions, which would operationalize this goal?
1. Teach stress reduction techniques such as relaxation and imagery.
  2. Explore client's need to single-handedly make up for a staff shortage.
  3. Explore ways that client may feel in control of her environment.
  4. Encourage client to attend a support group such as Overeaters Anonymous.
- 198.** The ultimate outcome of discharge planning is to give clients the knowledge, skills, and resources needed to assume self-care after discharge. The healthcare team members involved in this endeavor include:
1. nurses, physicians, and physical therapists.
  2. physicians only.
  3. social workers, nurses, physicians, and interdisciplinary team members such as physical and occupational therapists who have been involved in the current health care agency plan of care.
  4. nurses only.
- 199.** Managed care is:
1. a type of private physician's office.
  2. a fee-for-service type of insurance.
  3. available only in university health centers.
  4. a type of healthcare provider network that contracts to provide health services.
- 200.** An infant is born to a hepatitis B positive mother. The nurse can expect which of the following to be administered within 12 hours of birth?
1. MMR
  2. hepatitis B immune globulin alone
  3. hepatitis B immune globulin in addition to the vaccine
  4. Hib
- 201.** A primagravida is 12 weeks pregnant. The nurse notes she is rubella nonimmune. The nurse knows the client will be offered the rubella vaccine when which of the following events have occurred?
1. She reaches her 28th week of pregnancy.
  2. She begins labor.
  3. She requests the vaccine.
  4. She has delivered her baby.
- 202.** The nurse can expect to administer the rubella vaccine to her postpartum client under which of the following circumstances?
1. If her client is rubella nonimmune.
  2. If her client is rubella immune.
  3. If her client requests the vaccine.
  4. If her client has had previous exposure to rubella.
- 203.** One of the roles of the nurse in teaching clients must include all except:
1. family member/friend to help learn about care (client support system).
  2. primary health problem.
  3. cultural/health beliefs.
  4. group therapy with family.

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**204.** The National Alliance for the Mentally Ill (NAMI) is an important self-help/support group for consumers of mental health services and their social supporters. The major areas of NAMI are all except:

1. communicating that mental illness are brain disorders.
2. improving access to treatment services for people with mental illness.
3. communicating mental illness is completely treatable with medications.
4. integrating mental illness into general health and community life.

**205.** What can a nurse do to avoid feelings of frustration when establishing a relationship and working with a severely depressed client?

1. Expect the client to be receptive to the plans for nursing care.
2. Expect the client to be withdrawn and disinterested in a relationship.
3. Expect the client to show signs of improvement after several scheduled sessions.
4. Expect the client to show gratitude for attention.

**206.** A therapeutic relationship is:

1. unconditional and general.
2. cultural and formulation of a plan by the nurse.
3. personalized and client-focused.
4. interaction and touching.

**207.** The nurse observes halting speech from the client when her husband is present. Which of the following questions should the nurse ask to clarify interaction patterns?

1. "How do you and your husband spend your leisure time?"
2. "What is your level of education?"
3. "What is your husband's religious preference?"
4. "How does your husband communicate with you?"

**208.** A patient seen in the medical office you work in has been on two anticonvulsant medications for 3 years with excellent control of seizures. The physician decides to discontinue antiseizure medications. How will this proceed?

1. Both medications will be stopped simultaneously.
2. Drug A will be gradually reduced until off; then drug B will be gradually reduced until off.
3. Each drug will be reduced approximately 10 percent each week until off.
4. Each drug will be alternately reduced approximately 10 percent each week until off.

**209.** Monoamine oxidase inhibitors (MAOI) are used to treat depression. When given with certain drugs, serious interactions occur. Because of a cumulative affect, MAOIs should not be given concurrently with:

1. the beta-lactam antibiotics.
2. calcium channel blockers.
3. hypercholesterolemia agents.
4. selective serotonin reuptake inhibitors.

**210.** When is naloxone (Narcan) effective?

1. It is effective when the patient has overdosed on valium, a benzodiazepine.
2. Naloxone reverses the CNS depressant effects of the opiate agonists.
3. It is rapidly effective against CNS depression related to tranquilizer ingestion.
4. Sedative/hypnotic respiratory depression can be reversed by naloxone.

**211.** Acetaminophen (Tylenol, Datril, Tempra, Panadol) is:

1. a synthetic nonopiate analgesic used for mild to moderate pain relief.
2. an anti-inflammatory useful in the treatment of arthritis.
3. like aspirin, used for mild to moderate pain relief and to prevent platelet aggregation in patients at risk for myocardial infarction and stroke.
4. of little use as an anti-pyretic use to treat fever.

- 212.** All of the following indicate inadequate breathing except:
1. bilateral chest rise.
  2. tachypnea.
  3. bradypnea.
  4. agonal breathing.
- 213.** An elderly client was admitted to the hospital with difficult breathing. The nurse tried to assess the airway to give her oxygen but found it difficult because of her dentures and because older patients often have:
1. large, poorly chewed pieces of food found in their mouths.
  2. dysrhythmias, which occur frequently.
  3. a trachea that is usually narrower.
  4. arthritic changes in the bones of the neck.
- 214.** To determine the *quality* of breathing, check for all of the following *except*:
1. presence of breath sounds.
  2. chest expansion.
  3. breathing rhythm.
  4. depth of respirations.
- 215.** An unresponsive patient with shallow, gasping breaths with only a few breaths per minute requires:
1. oxygen given via nasal cannula.
  2. immediate transport to a medical facility.
  3. immediate artificial ventilation with supplemental oxygen.
  4. oxygen given via nonrebreather mask.
- 216.** A 23-year-old woman with a prolonged history of seizures treated with phenobarbital (Luminal) and phenytoin (Dilantin) delivers a 38-week gestation infant. On examination four hours after birth, the infant may be expected to exhibit:
1. digit and nail hypoplasia.
  2. seizures.
  3. omphalocele.
  4. drug withdrawal.
- 217.** Common side effects of analgesic drugs include:
1. insomnia and somnolence.
  2. constipation, nausea, and vomiting.
  3. seizures.
  4. nystagmus.
- 218.** A 28-year-old female complains of having a UTI. Which of the following symptoms would you expect her to exhibit?
1. proteinuria
  2. glycosuria
  3. syncope
  4. oliguria
- 219.** Adolescent pregnancy is viewed as problematic because:
1. the young males usually consent to marry.
  2. the vulnerability of and lack of resources for the mothers.
  3. detracts from marital adjustment.
  4. chief cause of venereal disease.
- 220.** The most favorable age range for reducing maternal and infant mortality and morbidity is:
1. 16–18 years.
  2. 14–15 years.
  3. 19–20 years.
  4. 20–25 years.
- 221.** Other factors that influence better pregnancy outcomes include all the following except:
1. spacing pregnancies between 2 and 4 years.
  2. optimal family size (number of pregnancies).
  3. acquiring a venereal disease.
  4. prenatal care.
- 222.** Family planning services are less available to:
1. poor people.
  2. rich people.
  3. adolescents without parental consent.
  4. Hispanics and other minorities.

- 223.** You observe one of your peers conduct a history and physical examination. The patient states that she wants a small mole she's had since birth removed from her left breast. The patient's present problem relates to insomnia. Your care-giver peer does not examine the breast mole. You are asked to critique the history and physical. Your most helpful response would be that your peer:
1. noted the patient's verbal statements.
  2. asked appropriate questions throughout the examination.
  3. needed to examine the mole.
  4. used focused attention toward the insomnia problem.
- 224.** Percussion of body tissue makes sounds that are:
1. soft over fluid.
  2. loud over air.
  3. dull over lungs.
  4. flat over gastric bubble.
- 225.** The physician and the nurse take a health history from the client. Which factor does the nursing health history assess that the medical one does not?
1. family health history
  2. status of body systems
  3. impact of illness on the client and family
  4. current health status
- 226.** Mary, a 16-year-old female, has acne all over her face. She feels rejected and not one of the crowd. This body image alteration is present because Mary:
1. desires to stand out in a crowd.
  2. desires to be like her peers.
  3. may have scarring on her face.
  4. does not see any clearing of the acne.
- 227.** Of the following procedures, which one causes change in the body image?
1. ingrown toenail
  2. facial melanoma
  3. fractured ankle
  4. fractured pinky finger
- 228.** The nurse is providing postoperative care to a patient who has had a craniotomy. Which of the following observations would require immediate attention?
1. continued unresponsiveness to verbal stimuli
  2. negative glucose reading in nasal mucus
  3. increased blood pressure and decreased pulse rate
  4. pale, warm skin and a temperature of 99°F
- 229.** Upon assessment, the nurse notes hepatomegaly, ascites, dependent edema, and jugular neck vein distention. The nurse understands that which of the following mechanisms accounts for these symptoms?
1. end-stage cirrhosis of the liver
  2. backward effects of right ventricular failure
  3. end-stage left ventricular failure
  4. backward effects of lymphatic obstruction
- 230.** A patient's renal function has been deteriorating during her hospitalization. The nurse monitors for significant changes by focusing on which of the following laboratory data?
1. decreased serum creatinine
  2. increased blood urea nitrogen
  3. increased creatinine clearance
  4. decreased serum potassium
- 231.** A patient complains of leaking urine when she coughs or laughs. This is known as:
1. functional incontinence.
  2. reflex incontinence.
  3. urge incontinence.
  4. stress incontinence.
- 232.** In right-sided heart catheterization, a catheter is inserted into which of the following blood vessels?
1. femoral artery
  2. femoral vein
  3. brachial artery
  4. radial vein
- 233.** Which of the following conditions is a contraindication for cardiac catheterization?
1. acute myocardial infarction
  2. diabetes mellitus
  3. poor renal function
  4. Pneumonia



- 234.** Where is a common site for capillary puncture in the newborn?
1. heel
  2. toes
  3. tibia
  4. arms
- 235.** Your client is a 97-year-old man who has severe coronary artery disease. His daughter informs you that he has a living will and a durable power of attorney for healthcare. These documents allow the daughter to:
1. sell her father's house for funds to be used in his care.
  2. make all decisions should her father become incompetent.
  3. make healthcare decisions based on her father's designated wishes if not competent or able to speak for himself.
  4. have no say in his care because the documents do not convey legal authority.
- 236.** You are helping Mrs. Smith with her mouth care before bed on the evening before she is scheduled for an exploratory abdominal surgery. She asks, "What do you think I should do if it's cancer?" You reply, "There's not much to fight. Cancer is a death sentence. Almost everyone I've taken care of with cancer dies in a short time." Your response is a statement of your:
1. personal values.
  2. professional values.
  3. ethical values.
  4. moral values.
- 237.** As Mrs. Smith's nurse it would be appropriate for you to share your personal values:
1. if you believe the client can benefit from your advice.
  2. when you need to make a choice for the patient.
  3. when the client asks for your opinion and you state it as such.
  4. when they will be used to settle a difference of opinion.
- 238.** Advocacy involves all of the following except:
1. maintenance of patient rights in clinical trials.
  2. care only for those who cannot defend themselves.
  3. education of patients regarding treatment choices.
  4. discouraging decision-making based on cost.
- 239.** The sequence of the case management process used by nurses includes:
1. implementation, coordination, planning, evaluation, assessment, and monitoring.
  2. assessment, planning, implementation, coordination, monitoring, and evaluation.
  3. assessment, planning, coordination, implementation, monitoring, and evaluation.
  4. assessment, planning, evaluation, coordination, monitoring, and implementation.
- 240.** A recently widowed 56-year-old patient is receiving dialysis and tells the nurse he does not like to cook for himself. As his case manager you would refer him to:
1. the local visiting nurses association.
  2. hospice.
  3. AARP.
  4. Meals on Wheels.
- 241.** Case management services begin with:
1. implementation of a case management plan.
  2. monitoring of the case management process in order to change plans if needed.
  3. assessment.
  4. evaluation.
- 242.** Case management processes are guided by:
1. standards of professional care.
  2. protocols of health care delivery.
  3. guidelines for clinical practice.
  4. all of the above.
- 243.** Rights of patients described in the American Hospital Association's "Patient's Bill of Rights" include all of the following except:
1. privacy and confidentiality.
  2. the right to refuse to participate in research.
  3. care without respect for continuity.
  4. the right to refuse treatment.

- 244.** Your patient is considering participating in a multi-site trial of a new cancer medication. According to the “Patient’s Bill of Rights,” it is important for the patient to know that:
1. all costs of research are paid by the patient.
  2. he has the right to refuse to participate in research without fear of loss of care.
  3. the physicians will no longer be caring for him if he does not participate in the research.
  4. the research study is his only hope of treatment.
- 245.** Organizational theory includes groups of related concepts that:
1. provide a structure for determining when to form an organization.
  2. are used to explain components of organization.
  3. are helpful in defining family dysfunction.
  4. are not helpful in defining outcomes for effective organizational functioning.
- 246.** Motivation is all of the following except:
1. the act of providing someone with an incentive.
  2. a state of mind in which a person views a task or goal.
  3. not possible in assisting a client to achieve a functional outcome.
  4. a process which assists a client to achieve a goal based on perceived need.
- 247.** Which of the following time management tips would be least useful and productive for a nurse manager?
1. Adopt a strategy which attempts to take care of all details.
  2. Work on the most important task first.
  3. Make a written note of tasks, activities and obligations to be completed.
  4. Accept assignments which she is capable of completing.

- 248.** At 8:30 AM on a Thursday morning, several small canisters exploded in a bus station. Later in the day many of the people who were present at the time of the explosion developed shortness of breath and muscle and chest pain. The hazardous materials (Hazmat) team has determined the canisters contained Ricin. All of the following statements about Ricin are correct except:
1. inhaled Ricin attacks the respiratory system, causing pneumonia and pulmonary edema.
  2. ingested Ricin causes gastrointestinal bleeding, which can lead to death.
  3. Ricin can be produced in an aerosolized form and solid form.
  4. symptoms of Ricin toxicity begin 48 to 72 hours after exposure.
- 249.** While attending closed medical case rounds, you are giving as a part of the teaching-learning process a detailed written case that is to be further discussed. In the course of the discussion, the identity of the patient becomes known to the group. You should:
1. dispose of any class notes in the regular trash.
  2. stop the discussion immediately after the identity of the patient is known.
  3. participate in the discussion while in class, but dispose of the case information in the shredded trash after the presentation.
  4. respect the patient’s confidentiality by leaving the presentation at the point at which the identity of the patient becomes known.
- 250.** The signs and symptoms of smallpox are similar to those of:
1. measles.
  2. meningitis.
  3. botulism.
  4. chicken pox.
- 251.** You are caring for a patient with peripheral vascular disease and diabetes who has venous ulcers. You may expect the patient to be seen by:
1. physical therapist.
  2. wound care nurse.
  3. durable medical equipment (DME) specialist.
  4. neurologist.

**252.** Home adaptations of restraints include all of the following except:

1. upper and lower side rails for bed.
2. high locks or alarms on doors.
3. covering tubing with towels.
4. flashlights for the patient to wear.

**253.** As a clinic nurse, one of your middle-aged patients tells you that she is concerned about her health as she wants to make changes to avoid and minimize health problems in the future. The focus of your patient teaching is on primary preventive care practices that:

1. help healthy people stay healthy.
2. help individuals with illness avoid complications.
3. help clients adapt to functional losses.
4. are covered entirely by insurance plans.

**254.** Family members had a variety of negative reactions to the restraining of their relative in acute care settings. These reactions were:

1. "She didn't do anything and she's tied up."
2. "My mother was overjoyed over the restraint, as it felt secure."
3. "The restraints are a good thing for older people."
4. "Collaboration is always excellent here, concerning restraints."

**255.** Potential quality indicators that may be the focus of unit-based quality improvement (CQI) activity on a med-surg unit are all of the following except:

1. medication errors.
2. incisional wound infections.
3. incidence of pneumonias post-operatively.
4. number of readmissions with primary diagnosis of CHF.

**256.** A nurse is planning to initiate a therapeutic relationship. The nurse recognizes that more time will be required for the orientation phase for which client?

1. a client who has resumed smoking after the death of a parent
2. a client who had become depressed after losing a job of 12 years
3. a client who has been hospitalized for severe depression twice before
4. a client who has exhibited behaviors of anorexia nervosa for two months

**257.** The goal of delegation is:

1. staff satisfaction.
2. workload distribution.
3. effective management.
4. prioritizing patient care needs.

**258.** Which activity is part of the termination phase of the therapeutic relationship?

1. selecting behaviors that will terminate the relationship
2. discussing the expectations of the nurse and client
3. relating feelings generated by separation to former losses.
4. selecting alternative responses to situations

**259.** Priority setting occurs during which step of the nursing process?

1. assessment
2. planning
3. intervention
4. evaluation

**260.** A client and nurse contracted to meet for 10 weeks. Beginning at the seventh week the client starts arriving late to the meetings and engages mostly in superficial talk. The nurse recognizes this behavior is:

1. because the client has other responsibilities.
2. due to the client's anger over the upcoming termination.
3. the client oversleeping due to increased depression.
4. a relapse of the progress made earlier in the relationship.

**261.** The teaching plan for a comprehensive sex education program should include all of the following goals except:

1. teach appropriate values, beliefs, and attitudes about sexuality.
2. communicate accurate information about sexuality.
3. help students develop relationships and interpersonal skills.
4. encourage the exercise of responsibility in sexual relationships.

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**262.** When reviewing the results of a youth risk survey about adolescent sexual behavior, which of these outcomes should receive priority in planning sex education programs?

1. Sixteen percent of students have had sexual intercourse with four or more partners.
2. Fifty-seven percent of currently sexually active students used a condom during their last sexual intercourse.
3. Twenty-eight percent of currently sexually active students used drugs or alcohol during their last sexual intercourse.
4. Seven percent of students have had sexual intercourse before age 13 years.

**263.** The nurse should recognize all of the following as developmental characteristics that increase the risk of injury in adolescents except:

1. strong need for peer approval.
2. begin to drive.
3. limited participation in sports.
4. increased access to complex tools.

**264.** The parents of an infant ask the nurse what kind of shoe they should buy for their child. The best response by the nurse would be:

1. "Your child needs high-top shoes to prevent the ankle from being injured as they begin to walk."
2. "Your child's shoes should be hard leather and be difficult to bend in the middle."
3. "You should buy your child shoes that leave at least an inch between the end of the longest toe and the shoe."
4. "You should buy your child new shoes about every 3 months between the ages of 2–3."

**265.** You are caring for a dying woman whose family is being asked to make an organ donation. You know that:

1. the family may make the decision for the organ donation if there is no indication that the woman was opposed to such a donation.
2. the Uniform Anatomical Gift Act allows a person to make a decision before death regarding donation of their organ(s) at the time of death.
3. documentation prior to becoming ill of the woman's desire for organ donation would assist the family in making a decision at the time of her death.
4. all of the above.

## Answers and Explanations for Practice Test 1

For your reference, the appropriate review chapter is listed at the end of each answer explanation below.

1. (2) One of the two indicators that the goal for implementing new coping patterns has been met is a willingness and ability to resume self-care responsibilities. Statement 2 shows that the client is taking care of their wig, a new self-care responsibility. Statement 1 shows denial that there has been hair loss and inappropriate self-care goals exist. Statements 3 and 4 also deny hair loss. The statements denying hair loss are evidence of the minor defining characteristics of body image disturbance still existing and the goal not being met. *Health Promotion and Maintenance*
2. (3) The client lost a limb. The most appropriate secondary cause is loss of body part. This will be a chronic condition, not necessarily a disease, but the most immediate cause of the body image disturbance is loss of body part. The body part was lost because of trauma, but using loss of body part is much more specific and immediately communicates to all other nurses the cause of the body image disturbance. There will be loss of body function as well that relates back to the loss of the body part. *Health Promotion and Maintenance*
3. (4) Statement 4 is the only statement that reflects a distorted image of the body. Clients with anorexia nervosa look in the mirror and see someone a lot heavier than they really are. They cannot see that they are too thin. Statements 1–3 indicate that the client is dissatisfied with something about their body. They don't like how it looks, or want to look like someone else, or wish they could wear certain types of clothing. But, those statements don't indicate that they don't see their body as it is. *Health Promotion and Maintenance*
4. (3) The major defining characteristic of body image disturbance is verbal or nonverbal negative responses to actual or perceived changes in structure and/or function of the body. Asking how the client feels about their disability will give them a chance to assess whether there is a negative or positive response to the change that has occurred. Mood can reflect how a client feels about themselves and/or their circumstances and can represent minor defining characteristics of disturbed body image. Families can have a great impact on how clients feel about themselves. It also helps determine the level of familial support. Family perceptions are not included in major or minor defining characteristics of disturbed body image. Determining whether the client is fearful, anxious, or nervous can help the nurse identify somatic problems associated with disturbed body image, but they are not major or minor defining characteristics. *Health Promotion and Maintenance*
5. (1) Elders experience an increased autoimmune response that puts them at increased risk for such diseases as rheumatoid arthritis and other collagen diseases. The number of T and B cells produced by the body is decreased, making the immune system less efficient. The reduction in T cells may play a role in increased malignancy rates in the elderly. Lymphoid tissue in the elderly is decreased, resulting in lower immune responses. The number of circulating lymphocytes in the elderly is reduced by about 15 percent along with a decline in antibody-antigen reaction making the elder more susceptible to infection. *Health Promotion and Maintenance*
6. (2) Elders tend to have masked signs of inflammation and infection and may not respond to them with as high a temperature or white blood count as a middle age person would. Therefore, nurses need to observe carefully for masked signs of infection and encourage the elder clients to contact their doctor even if they have a low grade temperature. Teaching stress management strategies gives the elder a way to overcome delayed or inadequate body responses to stress and ultimately promotes well-being. Eating a balanced diet with all the right nutrients helps the elder to overcome the delayed immune response and their increased risk for infection. Those elders who experience discomfort from the autoimmune disorders should be encouraged to contact their doctor so their pain can be treated. *Health Promotion and Maintenance*
7. (4) Themes or props can be used to stimulate discussion during reminiscence therapy. This can be particularly helpful in group settings. Elder clients should be allowed to repeat themselves during the discussion and not have attention drawn to the repetition. During the process of reminiscence both sad and happy memories are shared. The sharing of both should be encouraged. The nurse should avoid probing or pushing for details. The elder should be allowed to share informally and spontaneously. *Health Promotion and Maintenance*
8. (2) Ego Integrity versus Despair is the final stage of Erikson's psychosocial development. An indication of despair or self-disgust is manifested by the elder believing life has been too short and futile or that they want a chance to redo life. Statement 2 is consistent with despair. Signs of ego integrity are manifested by statements or

tasks that bring together all the previous phases of the life cycle. Manifestations of successful ego integrity mastery include activities such as volunteering at the library (the elder believes they still have something to offer), continued learning (those in ego integrity remain creative), and assisting others (helping people learn to read is still contributing to society). *Health Promotion and Maintenance*

9. (2) Oligohydramnios occurs when the amount of amniotic fluid is severely reduced. This would result in less than expected growth in the uterus, a fetus that is surrounded by so little amniotic fluid that it is easily palpated and outlined, and the fetus will not be palpable when the examiner does a vaginal exam and pushes against the cervix (ballottement). Hydramnios is more than expected amniotic fluid and would be evidenced by greater than expected uterine enlargement. There is an increased incidence of prolapsed cord and malpresentation at time of delivery. Macrosomia is the term applied to babies too large for gestational age. *Health Promotion and Maintenance*
10. (4) Fetal heartbeat can be detected with Doppler as early as 10–12 weeks of pregnancy and is considered a positive or diagnostic sign of pregnancy. Amenorrhea, the absence of menses, is considered a presumptive sign of pregnancy. It is a more helpful sign when more than one cycle has been missed. Uterine soufflé, the sound heard on auscultation over the uterus that is caused by blood flow through the placenta, can also be caused by other conditions such as ovarian tumors or uterine myomas. It is considered a probable sign of pregnancy. A positive pregnancy test is based on the detection of Human Chorionic Gonadotropin. It is present during pregnancy, but there are other conditions that can cause it to be elevated so it is considered a probable sign of pregnancy. *Health Promotion and Maintenance*
11. (3) By 20 weeks gestation the fetus is approximately 10 cm long or 7 1/2 inches. Fetal lungs do not begin the movements of respiration until 24 weeks. Because oxygen is provided through the placenta, the function of the lungs for breathing does not occur until birth. The fetus can open its eyes at 28 weeks gestation. Fingernails begin to grow at 10 weeks gestation but are not complete until 38 weeks. *Health Promotion and Maintenance*
12. (1) The first self-care measure to suggest is to practice frequent dorsi-flexion of the feet. If this is done, it would provide relief for two of the three symptoms the woman is experiencing: ankle edema and leg cramps. Wearing support hose would be a self-care measure if the woman was experiencing varicose veins but would have no effect on the symptoms listed. Avoiding standing for long periods of time is helpful for those with varicose veins. Avoiding standing in warm or stuffy environments may help with feeling faint. Again, the dorsi-flexion would help avoid ankle edema if the woman had to stand for long periods of time. Elevating the legs is helpful for ankle edema but is not a self-care measure for leg cramps or faintness. *Health Promotion and Maintenance*
13. (4) Newborns and young infants enjoy looking at themselves in the mirror. The human face is pleasing to them. Nurses must instruct parents to buy unbreakable mirrors to prevent injury. A jack-in-the-box may be fun for the parents, but a newborn does not have the capacity to turn the handle and make it work. This is too advanced a toy for a newborn. Neither a newborn nor a young infant possesses the fine motor skills necessary to squeeze an animal to produce the sound, nor do they have the capacity to associate the squeezing with the sound. Tooth eruption occurs at around 6 months of age. A newborn does not yet need a teething ring. *Health Promotion and Maintenance*
14. (1) Finger foods are just now being introduced into the infant's diet. Providing finger foods with different textures is a natural way to promote tactile stimulation. All of the remaining answers will provide tactile stimulation, but the question wants to know what to add. The infant has been having their hair combed with a soft brush for some time, and this would not be new stimulation. An 11-month-old has had soft squeeze toys since they were 4–6 months of age so this would not be an addition. A 4–6 month old should also have been allowed to play nude on soft, furry rugs so that again, this would not be new guidance. *Health Promotion and Maintenance*
15. (4) The order of the physical exam should be adjusted to accommodate the developmental age of the child and the response of the child to being examined. Since the child is quiet and distracted with the chew toy, the nurse should be able to get a good listen to the heart and lungs without the child crying or squirming. Taking the toy away will cause the child to cry, and while the nurse may get a good look in the mouth the respiratory, cardiac and abdominal exam will be compromised. It is usually late preschool or school-age before the nurse can do a complete head-to-toe without making adjustments in the order of the exam. Infants, toddlers, and many preschoolers view the ear and mouth exam as invasive and will cry if it is done first. By delaying it until the end good respiratory, cardiac, and abdominal assessments may be done. It is necessary to remove the infant's clothing, but it doesn't have to be done all at once, and that action alone may also cause the infant to cry. Slipping the stethoscope under clothing would allow the nurse to obtain that data without listening through cries. *Health Promotion and Maintenance*

- 16. (4)** The Babinski sign is positive in children 12 months of age and younger. A 16-month-old with a positive Babinski would be cause for concern and require further evaluation. A positive Babinski is normal for a 4-, 8-, and 12-month-old child and not a cause for follow-up. *Health Promotion and Maintenance*
- 17. (3)** The physician will order the leg to be kept straight for a prescribed time, to prevent the puncture site from bleeding. The other options do not apply. *Reduction of Risk Potential*
- 18. (4)** Applying pressure to the puncture site is the best action the nurse can take. The physician can be informed after pressure is applied. The client may bleed profusely if the nurse just monitors for changes! The findings can be documented later. *Reduction of Risk Potential*
- 19. (1)** The physician must be notified immediately, as these symptoms indicate a possible thrombosis, needing surgical intervention. Responses 2 and 3 can be done later. Response 4 does not indicate a hematoma, so applying pressure will not remedy the problem. *Reduction of Risk Potential*
- 20. (4)** Alcoholism creates risk for developing a low magnesium level due to nutritional deficiency. The other conditions do not. *Reduction of Risk Potential*
- 21. (2)** A normal adult pH ranges from 7.35 to 7.45. The other values fall below or above this range. *Reduction of Risk Potential*
- 22. (1)** These values are indicative of respiratory acidosis. The other values indicate other acid-base imbalances. *Reduction of Risk Potential*
- 23. (4)** Gestational describes the type of diabetes that develops during pregnancy. The remaining options are other types of diabetes. *Physiological Adaptation*
- 24. (2)** Lispro (Humalog) is a rapid-acting insulin that should be given at the time of the meal, not the other time frames. *Physiological Adaptation*
- 25. (4)** Diabetics need to dry feet thoroughly. They need to wash in warm water, wear shoes, and examine their feet daily. *Physiological Adaptation*
- 26. (1)** The role of the nurse in rehabilitative care is to have the client attain the maximum level of wellness on the continuum of all levels of prevention: primary, secondary, and tertiary. The nurse addresses levels of prevention; have the client become self-reliant, and continue the therapy previously on. *Basic Care and Comfort*
- 27. (3)** The purposes of the continuous passive devices (CPD) to move the knee joint without weight bearing or straining muscles and stimulating regeneration of articular tissues following orthopedic surgery for the knee. *Basic Care and Comfort*
- 28. (2)** The nursing care of a client using a CPM device encompasses aligning extremity in a padded CPM device; adjusting device according to client's extremity; setting the cradle and speed dials as ordered by the physician. The client should be frequently observed and shown the use of the control cord. *Basic Care and Comfort*
- 29. (1)** Rotator cuff tear decreases an individual's ability to reach across his/her body or toward the midline, which is adduction. *Basic Care and Comfort*
- 30. (4)** Normal mobility requires control, coordination, and strength. The CNS is the controller, coordination is muscle strength, bones, and PNS; and balance/coordination is through cerebellum function. *Basic Care and Comfort*
- 31. (4)** The wider the base of support, the more stable the nurse's body for support. Pelvic tilt is used to prevent lower back strain. Standing far away from patient requires more energy in supporting patient and higher risk of back strain. *Basic Care and Comfort*
- 32. (4)** Hematocrit of 32 is below the normal range of 37–47 percent ( $\pm 2$ ), which could indicate iron deficiency and possible body imbalance to increase changes of skin impairment as well as stress incontinence (ammonia) on the skin. In option 1, serum albumin is below normal, which could have some skin repercussions; peripheral edema-impairment of skin integrity; signs of depression-not necessarily involved. *Basic Care and Comfort*
- 33. (4)** Unkempt finger and toenails would be an area that is not cared for; the other areas could mean under lying possible disease processes or a scalp that has acquired seborrhea, or not thoroughly cleaned. *Basic Care and Comfort*

34. (1) Sims or side-lying position with head turned well toward dependent side to prevent possibility of aspiration. *Basic Care and Comfort*
35. (3) When recording the body temperature a basal body temperature thermometer or tympanic thermometer should be utilized. The basal body thermometer records a tenth of a degree rather than two tenths of degrees included on digital thermometers. The temperature should be taken and recorded upon awakening in the morning and before getting out of bed. Once activity occurs the basal metabolism rate rises resulting in elevated temperatures making the graph inaccurate for ovulation. The temperature should be recorded for 3–4 months in order to be able to use it to predict effectively ovulation. The rise in temperature means ovulation has already happened and reflects the rise in progesterone. *Health Promotion and Maintenance*
36. (2) The rhythm method is based on the assumption that ovulation occurs 14 days before the start of the next menstrual period (plus or minus 2 days). The fertile phase is calculated as 18 days before the end of the shortest cycle the woman has recorded for the past 6–8 months, and 11 days from the end of the longest recorded cycle. The woman should refrain from having intercourse during the calculated fertile cycle. That usually involves the second week of the cycle plus/minus a few days. The basic assumption of the rhythm method is that the ovum is viable for 24 hours, and the sperm is viable for 48–72 hours. *Health Promotion and Maintenance*
37. (2) The Billings method (or cervical mucus) of birth control is based on the assessment of cervical mucus changes related to ovulation. When the cervical mucus is clear it is more stretchable and permeable to sperm and is consistent with ovulation. This is the time a woman is most likely to become pregnant if she has unprotected intercourse. When the cervical mucus is thick and sticky progesterone is the dominant hormone and the physical characteristics of the mucus form a network that traps sperm, making it more difficult for them to progress up the reproductive tract. Options 3 and 4 both refer to abstaining from intercourse. Pregnancy is not likely when abstaining, regardless of the cervical mucus characteristics. *Health Promotion and Maintenance*
38. (4) One of the advantages of spermicides is that they provide significant protection from gonorrhea and Chlamydia. Douching after intercourse may facilitate conception as it pushes sperm farther up the birth canal. Coitus interruptus does require the male to withdraw from the vagina and ejaculate away from the external genitalia. Any cervical mucus on the external genitalia can facilitate the movement of sperm up the reproductive tract. Spermicides that effervesce offer rapid protection, and coitus can take place immediately after they are inserted. *Health Promotion and Maintenance*
39. (1) Lactulose may be given to the client with hepatic encephalopathy, in order to reduce ammonia formation, not the other options. *Physiological Adaptation*
40. (2) Protein is restricted in the client with hepatic encephalopathy, in order to reduce ammonia formation. Restrictions on the other dietary components would not have such an effect. *Physiological Adaptation*
41. (4) Nothing by mouth is an appropriate diet for the client with acute pancreatitis, as it will suppress pancreatic enzymes. The other diets do not accomplish this. *Physiological Adaptation*
42. (2) MAOIs can precipitate a hypertensive crisis when given with sympathomimetic amines or with foods containing certain amines. Such foods include aged cheeses, beer, Chianti wine, canned meats, raisins, and avocados. This effect can occur many hours after the drug serum level has declined. Because of adverse effects, MAOIs are not first-line therapy for depression. Shock results in a hypotensive condition. MAOIs do not interfere with the clotting cascade. MAOIs are non-sedating. *Pharmacological Therapies*
43. (3) Some older AEDs such as phenytoin (Dilantin), carbamazepine (Tegretol), and felbamate (Felbatol) can induce aplastic anemia, megaloblastic anemia, blood cell deficiencies including leukopenia, granulocytopenia, and thrombocytopenia, and immune hemolytic anemia. AEDs have no effect on vascular volume. AEDs do not affect immune modulators. AEDs do not induce fever. *Pharmacological Therapies*
44. (3) Nonselective beta blockers, such as propranolol, competitively block the effects of adrenergic agonists at  $\beta_1$  and  $\beta_2$  receptor sites.  $\beta_2$  receptor sites are found in smooth muscle such as that found in the airways. Blockage of  $\beta_2$  receptor sites in the airways can result in narrowing of the airway. In a patient with asthma a narrowed airway could precipitate a respiratory crisis. Beta blockers slow the heart rate. Beta blockers do not block calcium movement into myocardial cells. Beta blockers are not angiotensin receptor blockers. *Pharmacological Therapies*



- 45. (3)** With a low serum albumin more free phenytoin is available in the circulation. Free phenytoin is the active form of the drug. Hypoalbuminemia does not induce hypokalemia, CNS depression, or hyperalbuminemia. *Pharmacological Therapies*
- 46. (3)** The *best* answer for “holistic nature: is that the nurse has responsibility for maintaining the integrity of the whole person. Even though the other responses are true, they are not inclusive. *Basic Care and Comfort*
- 47. (1)** Therapeutic touch is used to restore the equilibrium of the energy field. *Basic Care and Comfort*
- 48. (3)** The goals of cognitive-behavioral interventions are to change clients’ perceptions of pain, to alter pain behavior, and to provide clients with a greater sense of control. *Basic Care and Comfort*
- 49. (2)** A full liquid diet allows such items as puddings, creamed soups, sherbet, strained cereals, and all items that are at room temperature. *Basic Care and Comfort*
- 50. (1)** Soft, flaccid muscles are signs of inadequate nutritional status. Muscles should be firm and well developed. All of the other options are signs of adequate nutrition. *Basic Care and Comfort*
- 51. (4)** Options 1 and 3 are all normal levels; option 4 is indicative of potassium depletion that occurs in severe cases of malnutrition. *Basic Care and Comfort*
- 52. (4)** The designated person who has legal rights to make decisions for a terminally ill patient, that is, regarding type and length of treatment, is known as Durable Power of Attorney (an Advanced Directive). *Basic Care and Comfort*
- 53. (4)** Hospice care is palliative care offered to patients at end of life. Care is focused on symptom control and pain relief (comfort). Hospice care is a multi-dimensional team approach and involves all members of the family. *Basic Care and Comfort*
- 54. (4)** Myelosuppression describes a deficit of cells produced by the bone marrow: RBC, WBC, and platelets. The patient will have increased risk for bleeding, infections, and anemia. There will be difficulty healing with myelosuppression. *Basic Care and Comfort*
- 55. (1)** Option 2 would be open, into the dermis; option 3 into the underlying fat and muscle; and option 4 to the bone *Physiological Adaptation*
- 56. (4)** This lesion favors warm moist folds, which are increased in overweight persons. Long-term steroid use also contributes; option 1 is ringworm, a round red scaly plaque with central clearing on non hairy skin—does not gravitate to the skin folds; option 2 is athlete’s foot, found between the toes; option 3 is a bacterial infection seen on exposed areas of the face, arms, and legs (not in the skin folds). It consists of small thin walled vesicles that crust. *Physiological Adaptation*
- 57. (1)** Stasis ulcers are caused by pooling of blood in the lower extremities due to incompetent valves, genetic predisposition, being overweight and/or prolonged standing. Compression and elevation decrease the stasis, skin care allows the ulcer to heal. Low-fat diet is used to treat arteriosclerosis associated with arterial rather than venous insufficiency; options 3 and 4 will cause increased stasis. *Physiological Adaptation*
- 58. (2)** Immobility is THE most important factor, closely followed by malnutrition (esp. albumin level < 3.5); options 1, 3, and 4 are less important risk factors. *Physiological Adaptation*
- 59. (1)** Victims of domestic violence are often correct at predicting their risk of harm. However, the nurse would ensure that the patient is expressing herself authentically and is not trying to convince the nurse that there is no immediate danger. Further, proper authorities should be alerted to this reportable offense such as the police. *Psychosocial Integrity*
- 60. (1)** There is a correlation in vague symptoms such as abdominal pain and battered syndrome. The astute clinician should ask any woman who presents with suspicious symptoms such as these. Rarely are women offended by a properly worded question, such as, “Do you feel safe in your present relationship?” and studies show the increase in case-finding that results by even one such question. It is not mandatory that all women are assessed for violence, but it is prudent that all persons new to a clinician be assessed by at least the one question noted. Castigating or shaming the MD will typically not improve patient outcomes and may make for a difficult working environment for the nurse. Such tactless comments are not collegial and should be avoided. *Psychosocial Integrity*

- 61. (4)** Although 40 percent of Hispanic Americans have limited English proficiency, few healthcare providers speak Spanish. Disparity exists in access, use, and quality of care for minority cultures. *Psychosocial Integrity*
- 62. (2)** Women have more diagnoses of depression and anxiety, while men have more diagnoses of substance abuse. African Americans are more likely to suffer mental disorder than their white counterparts, but less likely to seek treatment. The rate of mental illness is similar in white and Hispanic cultures. Asian Americans and Pacific Islanders are less likely to seek care for mental disorders. American Indians and Alaskan Natives have a higher incidence of depression and substance abuse than whites. *Psychosocial Integrity*
- 63. (2)** An interdisciplinary approach is best in management of pediatric abuse. The MD's failure to recognize the signs/symptoms of abuse must be questioned. However, the child's safety requires outside evaluation and probable removal from the present environment. Local civil authorities (police, child protective agencies, and so on) will assist the nurse in ensuring the child is protected from further physical harm. In a situation as described, the nurse may want to elicit the support and assistance of the department's or hospital supervisor. The suspicion of abuse is a reportable incident by law and the nurse is mandated to comply. *Psychosocial Integrity*
- 64. (4)** Post traumatic stress disorder often follows exposure to a traumatic event involving the threat or belief of threatened death or serious injury to self or someone close to the person (sibling, parent). Schizophrenia and bipolar disorder have a strong genetic component although stressful events may exacerbate these conditions. Paranoia, delusional thoughts of persecution, often accompanies disorders such as schizophrenia. *Psychosocial Integrity*
- 65. (1)** A continuum of sexual responses exists that is free of moral judgment and was developed to help nurses understand the range of sexual responses. The most adaptive sexual response is option 1. Adaptive sexual responses include sexual behavior between two consenting adults, mutually satisfying to both, not psychologically or physically harmful to either, lacking in force or coercion and conducted in private. Option 4 is at the opposite end of the continuum and represents the most maladaptive sexual response. The order of the continuum from most adaptive to most maladaptive is option 1, 2, 3, and 4. *Health Promotion and Maintenance*
- 66. (3)** It is critical for the nurse to know themselves and be aware of their feelings and values regarding sexuality. If they do not, they will not be able to help patients. The first step in developing the awareness is cognitive dissonance, which occurs when a situation arises that cause two opposing beliefs to exist. For example the nurse may have been raised to not discuss sexual matters but recognizes that as a professional nurse she/he should be able to discuss sexual concerns with the patient. Anxiety is the second step in which the nurse recognizes that uncertainty, insecurity, questions, and problems regarding sexuality are normal. The third step in the process is anger that generally arises after anxiety, fear, and shock subside. The nurse begins to recognize that issues associated with sexual behavior are sometimes emotional and volatile. The final step in the process of self awareness is action. During the action phase the nurse is able to experience data inquiry, choose values, and prize values. The nurse finds healthy ways to explore and decide what to believe. *Health Promotion and Maintenance*
- 67. (3)** Transsexualism is a term applied to individuals who experience a mismatch between their biological sex and their gender identity. Transsexuality is different from homosexuality in that homosexuals are comfortable with their biological sex and do not want to change their sex. They are sexually attracted to members of the same sex. Many transsexuals are heterosexual and believe they belong to the other sex. Bisexuals are individuals who are sexually attracted to both men and women. Transvestites are usually males who dress in female clothing. They tend to be married men with heterosexual behavior. They do not want hormonal or surgical treatment. *Health Promotion and Maintenance*
- 68. (3)** When the orgasm stage of the sexual response cycle is disrupted in males they may experience premature or retarded ejaculation. Absence of the desire stage will be characterized by hypoactive sexual desire disorder or sexual arousal disorders. When the excitement phase is inhibited there may be erectile dysfunction. Interruption or inhibition of the resolution phase rarely results in any specific sexual dysfunctions. *Health Promotion and Maintenance*
- 69. (2)** A biologic male typically has XY chromosomes. Males with Klinefelter's syndrome have triple chromosomes with an additional X or Y chromosome, yielding an XXY or XYY pattern. A biologic female has XX chromosomes. Females with Turners syndrome have single chromosomes with a missing X chromosome or a single chromosome XO. *Health Promotion and Maintenance*

- 70. (2)** A 9–12 year old is likely to respond to divorce with intense anger, somatic complaints, and confused self-identity. Increased aggression is characteristic of a 3–5 year old whose parents have divorced. Extreme sadness is mostly likely to be experienced by 6–8 year olds whose parents have been divorced. Adolescents will experience anger, less than pre-adolescents, when parents divorce. *Psychosocial Integrity*
- 71. (2)** According to the DSM-IV-TR essential features of a family experiencing partner relational problems include a pattern of interaction characterized by negative or distorted communication or noncommunication associated with clinically significant impairment in one or both partners. Option 1 is an essential feature of parent-child relational problems. Option 3 is an essential feature of sibling relational problems. Finally, option 4 is an essential feature of relational problems not otherwise specified. *Psychosocial Integrity*
- 72. (4)** To determine the family structure the nurse must assess the leadership and distribution of function. When assessing for conflict resolution the nurse should look at the family processes of resolving differences of opinion. Problem-solving abilities can be assessed by how a family considers alternative lines of action. The amount and clarity of information exchange will help the nurse assess the family's communication. *Psychosocial Integrity*
- 73. (3)** The family APGAR is a system to assess the degree of satisfaction that exists within the family. Social support systems may be important to how a family functions but is not included in the APGAR as it doesn't assess the interactions within the family. Besides the categories listed in options 1, 2, and 4 the APGAR assesses nurturing and freedom to explore new roles and how space, time, and money are shared. *Psychosocial Integrity*
- 74. (3)** Healthy, functioning families maintain emotional contact across the generations and between family members while maintaining the necessary lines of authority. Children in functioning families are responsible for age-appropriate activities and have age-appropriate privileges. Functioning families encourage differences between family members so that each member can enjoy personal growth and creativity. In functioning families differences are resolved between the two members who are having the problem without having to involve an outside third party. *Psychosocial Integrity*
- 75. (3)** The client is most at risk for impaired skin integrity. This is because in Buck's traction, elastic wraps are placed around the leg in order to maintain traction. There is the possibility of skin breakdown under the wraps. The nurse needs to assess the skin at least every 4 hours. The other diagnoses do not necessarily apply to the client in Buck's traction. *Reduction of Risk Potential*
- 76. (3)** Swelling of the hand should be reported to the doctor, as it may indicate a developing complication. A coat hanger should not be inserted inside a cast, as it could cause a scratch that could become infected. A plaster cast is not waterproof, so a "short shower" cannot be taken, unless the cast is wrapped in a barrier of plastic wrap. If the cast is damaged in any way, the healthcare provider needs to be notified. *Reduction of Risk Potential*
- 77. (2)** Brown-Séquard syndrome is a result of damage to one-half of the spinal cord. This is not associated with fractures. The remaining options are complications that may result from fractures. *Reduction of Risk Potential*
- 78. (1)** The client should not ever cross his legs, as this may cause dislodgement of the hip prostheses, particularly in the early postoperative period. The other statements are correct and indicate adequate understanding. *Reduction of Risk Potential*
- 79. (4)** Effective coping may include verbalizing feelings (one-on-one or in groups) or distraction. However, taking on additional work would only serve as an additional stressor. In addition, a nurse who has not begun resolution of these feelings is unlikely to be able to meet client's emotional needs. *Psychosocial Integrity*
- 80. (4)** Wearing eyeglasses is another example of beginning a new strategy to assist with what will be a lifelong health need. Interviewing for a job is a very short-lived situational stressor. Coping strategies effective while a teenager may not be relevant at age 50. Experiencing the stress of divorce is a social/role stressor quite unlike that of a health problem. *Psychosocial Integrity*
- 81. (1)** Developmental stressors, such as menopause, the climacteric, aging, and impending retirement and situational stressors, such as divorce, unemployment, and death of a spouse, can precipitate increased anxiety and depression in middle-aged adults. *Psychosocial Integrity*
- 82. (1)** Health Promotion activities in Mental Health are to utilize the nursing process and identify the risk factors that are inherent in their lives in order to motivate them to reduce specific risks and develop more positive health habits. *Psychosocial Integrity*

- 83. (2)** Definition of tolerance is a state in which a particular dose fails to elicit the prior effect and to achieve the desired prior effect more of the substance must be taken. While long-term use of some substances such as opioids may produce physical tolerance to euphoria and respiratory depression, little to no physical tolerance develops to constipation and miosis. *Psychosocial Integrity*
- 84. (1)** Although other factors such as cultural norms and beliefs exist when defining addiction, the American Society of Addiction Medicine defines it as a disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological, and social harm. *Psychosocial Integrity*
- 85. (4)** Type O blood is known as the universal donor, as it does not have red blood cell agglutinins with the other blood types. The remaining options have agglutinins with other blood types and could cause a transfusion reaction. *Reduction of Risk Potential*
- 86. (3)** Type AB is the universal recipient, as the other blood types are compatible when it is given. When the remaining options are given to someone with a different blood type, it can cause a transfusion reaction. *Reduction of Risk Potential*
- 87. (4)** Chest tightness, anxiety, and shortness of breath are signs of a transfusion reaction. The nurse must first stop the infusion, to prevent any further infusion of blood, which would only worsen the situation. The remaining options can be done afterward. *Reduction of Risk Potential*
- 88. (3)** Nurses must refrain from furthering the delusion or discounting it. Logical explanations are not helpful. A simple phrase stating the nurse does not see the stimuli will help the client gain trust and distinguish reality from delusion. *Psychosocial Integrity*
- 89. (1)** Clients with antisocial personality disorders manipulate others. The first option emphasizes client responsibility while showing respect for the client. The other options are punitive and result in the client feeling wronged. *Psychosocial Integrity*
- 90. (2)** Victims of sexual abuse may develop post traumatic stress disorder in which the feelings may return. An intervention would be to explore recent events that might have triggered the feelings. *Psychosocial Integrity*
- 91. (1)** The client may display a wide range of reactions after a rape. Common reactions to rape, as any other crisis event, include numbness, isolation, anxiety, and fear. *Psychosocial Integrity*
- 92. (4)** Hepatitis B is spread through blood and body fluids so it is very important that the nurse discuss the use of barrier protection such as a condom for sexual intercourse with the patient in order to prevent the transmission of this disease. Eating large meals three times a day may actually cause the client to have nausea. It is recommended that the client eat small meals throughout the day to avoid this complication. Alcohol is broken down in the liver; therefore, the client must avoid alcohol for 1 year in order to allow for recovery. The CDC does recommend immunoglobulin for post exposure of Hepatitis B. It is also recommended that the close friends and family members be vaccinated with the Hepatitis B vaccine. *Health Promotion and Maintenance*
- 93. (4)** Untreated gonorrheal eye infections in the newborn can cause permanent blindness and, therefore, the laws in many states require the administration of this medication. HIV and AIDS, Herpes, and Syphilis do not cause blindness but other preventive measures may be taken to prevent the transmission of these diseases from the mother to the infant. *Health Promotion and Maintenance*
- 94. (4)** All of these programs are disease prevention programs. The prostate and breast exam clinic will aid in the prevention and early detection of cancer and the immunization clinic will provide immunity from life-threatening illnesses. *Health Promotion and Maintenance*
- 95. (2)** Percussion is the use of sound waves to detect body tissue density. Percussion tone is loud over air, medium loud over fluid, and soft over solid areas. Proceed from areas of resonance to areas of dullness. Firmly place middle distal phalanx on surface. Snap wrist and tap tip of the same finger of opposite hand onto placed finger. First percussion is used to elicit liver, kidney, and gallbladder tenderness. *Health Promotion and Maintenance*
- 96. (3)** Unlike the physician, the nurse takes a health history to assess the impact of illness on the client and family and to identify educational and discharge planning needs. The nursing health history takes a holistic view of the client and provides insight into actual and potential problems. This allows the nurse to develop an individualized care plan and provides an opportunity for client teaching. *Health Promotion and Maintenance*

- 97. (2)** The genogram organizes family history data and is used to identify an actual or potential and familial health problems. This is a tool the nurse can use to gather information about the family. A genogram interview makes the family feel the nurse is interested in the whole family. This genogram is one part of a comprehensive clinical assessment of the family. *Health Promotion and Maintenance*
- 98. (1)** is correct. Choices 2, 3, and 4 are incorrect. Neither financial or personal property disbursements are included in a living will. *Coordinated Care*
- 99. (3)** Nursing advocacy includes the encouragement and support of independent patient decision-making. It is built upon the ethical principle of autonomy and self-determination. *Coordinated Care*
- 100. (2)** Choosing treatment options for a patient based on geography rather than the patient's choice of need-based treatment provider is incorrect; all other answers are appropriate. *Coordinated Care*
- 101. (3)** Most perpetrators fall into three categories; the angry, the power oriented and the sadistic. Rape is always an act of violence typically perpetrated by a male against a female. There is no preponderance of racial, psychiatric, or mental retardation disorders associated with perpetrators, and the risk of an STD is the same or higher during rape. *Safety and Infection Control*
- 102. (2)** Sensitivity testing allows a client who actually has the disease to be correctly identified. Most lab tests are regulated via CLIA (Clinical Laboratory Inspection Agency) and OSHA (Occupational Safety Health Administration) and do not fall under the regulation of the FDA (Food and Drug Administration). Clinical testing includes some extrapolation and normalization of data for elements such as controls and ranges; however, individual test results are typically based on the actual individual's test result. *Safety and Infection Control*
- 103. (2)** By determining women who have been exposed to rubella and developed sufficient titers to be considered immune, the risk of rubella infection can be predicted for other pregnant women. Rubella is a severe teratogenic and is the causative agent for congenital rubella syndrome; a severe congenital disease that may result in spontaneous abortion, heart, CNS, vision and hearing gross abnormalities. Immunization against rubella is contraindicated during pregnancy as the rubella vaccine is a live vaccine. *Safety and Infection Control*
- 104. (3)** Impetigo is spread by direct contact with secretions from the lesion. Covering such topics as skin care, frequent handwashing, and early quarantine would correlate with impetigo skin infection. Bacterial pharyngitis may warrant warm salt water gargles for comfort, and increased fluids but there would be no indication for a high-fat diet or use of eye protection. *Safety and Infection Control*
- 105. (3)** The Patient Bill of Rights developed by the American Hospital Association defines the rights and responsibilities of patients in acute care settings. The ANA code of Ethics provides guidance for nurses regarding ethics. Hospital Advocacy is a program used by hospitals to assist patients in decisions concerning their rights and healthcare choices. OBRA is related to quality of care in long-term care facilities. *Coordinated Care*
- 106. (4)** As aggressive behavior dominates or embarrasses, passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness. This case exemplifies assertive behavior. *Coordinated Care*
- 107. (3)** Confidentiality is a right of healthcare patients that supports the belief that information, both verbal and written, given to all healthcare providers will be kept private and not disclosed except in very specific situations (specific safety concerns). Confidentiality does extend to patients whose competence may be in question or who have been deemed incompetent by the courts in that information is shared only with or at the discretion of the person named the legally responsible party for the incompetent patient. *Coordinated Care*
- 108. (3)** The speech therapist will be the most important member of the healthcare team to deal with aphasia, which is the defect or loss of language in comprehension or expression of words is impaired as a result of injury to or degeneration of the language centers in the cerebral cortex. *Coordinated Care*
- 109. (3)** All of the choices listed are influential in an individual's health beliefs and practices; however family practices are considered to be an external resource. *Coordinated Care*
- 110. (1)** Neurosyphilis, secondary, and tertiary may present with altered mental findings. The causative organism of syphilis is *treponema pallidum*, a spirochete. *Safety and Infection Control*

- 111. (4)** Azithromycin or Doxycycline should be used to treat the sexually transmitted disease, Chlamydia. Ceftioxone, a cephalosporin is not active against Chlamydia nor is the anti-fungal, Metronidazole, and Amoxicillin is resistant to most gram-negative infections. *Safety and Infection Control*
- 112. (1)** Penicillin is still the drug of choice for most strep pharyngitis. Tetracycline is not active against most strep infections and Acyclovir is an antiviral drug while Metronidazole is an anti-fungal. *Safety and Infection Control*
- 113. (3)** Ensure safety of the client in using restraints. Document reasons for using restraints, type, time, and other pertinent information. *Safety and Infection Control*
- 114. (1)** Restrained clients often become (more) restless and anxious as a result of the loss of self-control. Nurses must document that the need for the restraint was made clear both to the client and to support persons. *Safety and Infection Control*
- 115. (2)** Restraints are protective devices used to limit the physical activity of the client or a part of the body. *Safety and Infection Control*
- 116. (3)** Causes include: Usually, hyperkalemia results when the patient's kidneys fail to eliminate sufficient potassium. Other possible causes include: Increased dietary potassium (especially with decreased urine output); excessive use of oral potassium supplements; excessive administration of IV potassium preparations (most common); excessive use of salt substitutes or potassium-sparing diuretics such as spironolactone; injury to cells (from burns, sepsis, trauma, crush injuries, and intravascular hemolysis); lysis of malignant cells from chemotherapy; receipt of a large volume of blood that's nearing its expiration date.
- Hyperkalemia may also accompany hyponatremia, hypoaldosteronism, metabolic acidosis, acute or chronic renal failure, sickle cell anemia, or systemic lupus erythematosus. Medications that may contribute to potassium imbalance include beta blockers and some antibiotics, such as penicillin G potassium. *Physiological Adaptation*
- 117. (2)** Muscular weakness, irregular pulse, hypotension, severe-flaccid paralysis that spreads from legs to trunk; respiratory muscles may also be affected. *Physiological Adaptation*
- 118. (1)** IV calcium gluconate is administered to counter the myocardial depressant effects of hyperkalemia; Glucagon or insulin and glucose treatment to prevent tissue breakdown and potassium release into extracellular fluid. *Physiological Adaptation*
- 119. (2)** Calcium serum levels 4.5 – 5.5mEq/L. (8.9 – 10.1 mgm/dl) Calcium is the majorcation involved in the structure and function of bones and teeth; approximately 99 percent of this mineral is concentrated in bones and teeth; most of the remaining 1 percent is in the extracellular fluid (ECF). *Physiological Adaptation*
- 120. (3)** Sickle cell anemia is an incurable hereditary blood disease found primarily in black populations in which deformed sickle-shaped red blood cells cause a chronic form of anemia; deformed red blood cells block small blood vessels, reducing blood flow; clients should avoid factors that may trigger sickle cell crisis, including excessive alcohol consumption, dehydration, fatigue, extreme heat, high altitudes, and emotional stress; the client needs to identify and change lifestyle patterns that can precipitate crises in an attempt to maintain well-being. *Physiological Adaptation*
- 121. (1)** The underlying cause of aplastic anemia is unknown, but exposure to certain drugs, chemicals, radiation, and infections has been linked to the disorder; it is believed that these agents cause depressed bone marrow activity and lead to the replacement of marrow by fat cells; aplastic anemia is defined as depressed bone marrow activity with low productions of erythrocytes, leukocytes, and platelets. If the patient receives dialysis, folic acid should be given to the replace what passes into the dialysate; the patient with aplastic anemia is at risk for development of infection as a result of the development of granulocytopenia; treatment includes bone marrow transplants, administration of immuno-suppressants therapy with antithymocyte globulin (ATG), blood transfusions, antibiotics for the treatment of infections, high dosages of corticosteroids. *Physiological Adaptation*
- 122. (3)** Because of the granulocytopenia associated with AML, these patients are at high risk for development of infection. Infection is the major cause of death in patient with leukemia, and therefore the slightest indications of infection must be assessed and treated at once; weakness and fatigue occur in patient with AML as a result of anemia caused by defective erythropoiesis; bruising occurs in patient with AML as a result of thrombocytopenia. Bleeding tendencies are usually associated with fever or infection. *Physiological Adaptation*



- 123. (2)** Leukemia—any of several types of cancer in which there is a disorganized proliferation of white blood cells in the bone marrow; acute lymphatic leukemia (ALL) has as symptoms—fever, bleeding, enlarged lymph nodes, fatigue, weakness, symptoms of “blast crisis”; treatment includes chemotherapy with combinations of asparaginase (Elspar), prednisone, and others; nursing—encourage walking, hydration (measure fluid intake and output), rest, close medical care, teaching, emotional support. *Physiological Adaptation*
- 124. (3)** Each year the older individual and the physically compromised should be given appropriate flu vaccine, as well as a pneumococcal vaccine and other vaccine that may be necessary. It should be given prophylactically to residents of nursing homes and other institutions with high risk patients. Since 1957, there have been at least 19 influenza epidemics in the United States in which more than 10,000 persons died. Influenza vaccine is prepared each year in an attempt to anticipate antigenic variation among influenza viruses. Two strains of influenza A and one strain of influenza B are selected based on circulating strains. These vaccines provide moderate antibody protection against influenza viruses with the same antigenic characteristics. Protective efficacy is estimated to be 65–80 percent in young adults but only 30–40 percent in preventing illness in older adults, who account for 80–90 percent of influenza deaths. The vaccine is estimated to have higher efficacy (50–60 percent) in preventing hospitalization and pneumonia in older adults. The vaccines do not protect against infection with antigenically dissimilar influenza strains. *Physiological Adaptation*
- 125. (4)** Because mosquitos feed at night, being out after dusk increases the risk of acquiring the disease. Malaria is a parasitic disease; infections with the four human malarias can present sufficiently similar symptoms to make species differentiation generally impossible without laboratory studies. Furthermore, the fever pattern of the first few days of infection resembles that seen in early stages of many other illnesses (bacterial, viral, and parasitic). Malaria may present a quite varied clinical picture, including fever, chills, sweats, cough, diarrhea, respiratory distress and headache, and may progress to icterus, coagulation defects, shock, renal and liver failure, acute encephalopathy, pulmonary and cerebral edema, coma and death. It is a possible cause of coma and other CNS symptoms, such as disorientation and delirium, in any nonimmune person recently returned from a tropical area. Prompt treatment is essential, even in mild cases, since irreversible complications may appear suddenly; case-fatality rates among untreated children and nonimmune adults can be 10–40 percent or higher. Travelers to malarious areas need to realize that protection from biting mosquitoes continues to be of paramount importance; no antimalarial prophylactic regimen gives complete protection; prophylaxis with antimalarial drugs should not automatically be prescribed for all travelers to malarious areas; and “standby” or emergency self-treatment is recommended when a febrile illness occurs in a falciparum malaria area where professional medical care is not readily available. *Physiological Adaptation*
- 126. (3)** If Ms. Roberts does not volunteer information about her depression, it would be inappropriate to discuss it with her and in fact would be an invasion of her privacy. *Physiological Adaptation*
- 127. (1)** In shock, the cells lack adequate blood supply and are deprived of oxygen and nutrients, therefore they must produce energy through anaerobic metabolism. This results in low energy fields and an acidotic intracellular environment. The cell membrane becomes more permeable. *Physiological Adaptation*
- 128. (2)** Urgent. Individuals who require first aid, but not immediate treatment; fast tract or urgent care areas have been developed because these care environments are less expensive treatment areas; persons treated in these areas require less time with health care staff, because of the nature of the signs/symptoms. *Physiological Adaptation*
- 129. (2)** Immediate. A yellow tag from field triage indicates the patient has a nonacute, nonlife-threatening injury or illness requiring attention and management without significant delay. These victims can wait for transportation after they receive initial emergency treatment. They include victims with immobilized closed fractures, soft-tissue injuries without hemorrhage, and burns less than 40 percent of the body. *Physiological Adaptation*
- 130. (4)** Although the consent to examine and treat is required, if the patient is unconscious and brought to the ED without family or friends, the information is documented and treatment is not delayed. Time tracking of patients, recording of the status of the client are essential areas for the nurse to set as first goal. Early intervention is the key to effectiveness. *Physiological Adaptation*
- 131. (1)** Diphenhydramine HCl is an antihistamine. Its use prior to a blood transfusion decreases the likelihood of a transfusion reaction. The product in option 2 may or may not induce drowsiness in a patient. However, it is not necessary for this patient to sleep during a blood transfusion. The product in option 3 may decrease or eliminate sneezing related to an allergy in a patient. However, if the IV device is properly secured, sneezing will not dislodge it. The product in option 4 does not prevent the transmission of hepatitis. *Pharmacological Therapies*

- 132. (3)** Platelets may be given when a patient's platelets are not functioning properly due to illness, medicines, or mechanical damage caused by an artificial heart valve. Thrombocytopenia resulting from chemotherapy does not last two years. Donating bone marrow does not necessitate a platelet transfusion for the donor. Congenital heart disease does not result in thrombocytopenia. *Pharmacological Therapies*
- 133. (1)** Fibrinolytics, such as streptokinase, urokinase, and alteplase, stimulate the conversion of plasminogen to plasmin. Plasmin is a proteolytic enzyme which is able to disrupt fibrin stability and production and dissolve clots. Heparin prevents but does not dissolve clots. Protamine counteracts the anticoagulant effect of heparin. The product in option 4 will not dissolve clots and restore patency of the catheter. *Pharmacological Therapies*
- 134. (2)** CVP represents the average blood pressure within the venous compartment. It is measured in the thoracic vena cava near the right atrium. It is used to make an estimate of a patient's blood volume. The measurements in options 1, 3, and 4 require a catheter located in vessels other than a central vein. *Pharmacological Therapies*
- 135. (3)** Antimetabolites are structural analogues of folic acid, purine, or pyrimidine bases found in DNA. They inhibit cell growth and proliferation by inhibiting enzymes required for DNA base synthesis. This limits the chemical and physical processes of the cell. Antimetabolites do not promote cell growth. Antimetabolites do not destroy the bone marrow. Antimetabolites may have some limitation on cancer metastasis but it is an indirect effect caused by inhibition of cell growth and proliferation. *Pharmacological Therapies*
- 136. (2)** The active ingredient in this agent is  $\Delta^9$ -tetrahydrocannabinol or THC. THC modulates the activity of acetylcholine, dopamine, and serotonin. Dopamine and serotonin activate the chemoreceptor trigger zone which activates the vomiting center in the medulla. Dronabinol can induce mild stimulation followed by depression. Dronabinol has no pain relief properties. Dronabinol does not reduce or treat inflammation of the oral mucosa. *Pharmacological Therapies*
- 137. (3)** Low doses of aspirin inhibit thromboxane A<sub>2</sub>, a potent prostaglandin responsible for thrombus formation. Aspirin is an antipyretic and anti-inflammatory agent. However, in the treatment of MI it is used to prevent platelet aggregation in the coronary arteries. Aspirin does not reduce the pain associated with MI. *Pharmacological Therapies*
- 138. (2)** NSAIDs irreversibly inhibits cyclooxygenase, the enzyme responsible for prostaglandin synthesis. Prostaglandin triggers inflammation. Blocking prostaglandin production reduces the inflammation and pain associated with arthritis. In options 1, 3, and 4 the key word is "treating." Mediating inflammation is the only possible answer since the other three choices are not treatments. *Pharmacological Therapies*
- 139. (4)** The term gauge is a standard method of measuring the internal diameter of a needle. However, the higher the number the smaller the gauge. For example, a 20-gauge needle is smaller than a 16-gauge needle. Statements 1 and 2 are incorrect. The area in statement 3 is called the hub. *Pharmacological Therapies*
- 140. (1)** A liter of IV fluid contains 1000 milliliters. This amount divided by a run time of 4 hours equals 250 milliliters per hour. The nurse can calculate this rate without asking the physician or pharmacy for the answer. If the infusion is uncomfortable at the correct rate, the nurse must obtain further orders from the physician. *Pharmacological Therapies*
- 141. (3)** Alimentation is the act of supplying food and nourishment. Hyperalimentation or total parenteral nutrition supplies nourishment using the intravenous route. The TPN solution can be adjusted to meet each specific patient's needs. Administration of TPN is expensive and requires either a central venous line or peripheral IV. IV sites and the infusion must be monitored. Option 2 is not a definition. *Pharmacological Therapies*
- 142. (4)** In patients unable to take oral nutrition, or when oral nutrition is inadequate, parenteral hyperalimentation provides nutritional support. High concentrations of dextrose, amino acids, minerals, vitamins, and trace elements can be provided. Infection is not prevented. In fact, the risk of infection is increased in patients receiving a high glucose infusate, especially if administered through a central venous line. Option 2 is not the primary value of TPN. The symptoms in option 3 are related to the chemotherapy. Taking nothing by mouth does not eradicate them. *Pharmacological Therapies*
- 143. (1)** All of the above require a needle/syringe. The intravenous route also requires an infusion catheter, and possibly IV tubing and an infusion pump. The methods in options 2, 3, and 4 are less expensive and involve only a syringe. *Pharmacological Therapies*



- 144. (1)** The deltoid is readily available and injections are usually well tolerated. The gluteus maximus may be used for very thin adults with little deltoid muscle mass or if a large volume of medication is to be administered. The anterolateral thigh is the preferred injection site for infants and small children. Very few medications are administered in the abdominal tissues; of note is insulin and heparin. *Pharmacological Therapies*
- 145. (2)** Most sleep during a night is NREM sleep. It is a deep, restful sleep that brings a decrease in physiological functions. *Basic Care and Comfort*
- 146. (2)** NREM stage I sleep is characterized by very light sleep in which the person feels drowsy or relaxed and with the eyes rolling side to side. The heart and respiratory rate drop slightly. *Basic Care and Comfort*
- 147. (4)** Stage IV is thought to be the stage that restores the body physically. Stage III is the domination of PSNS and the sleeper is difficult to arouse. *Basic Care and Comfort*
- 148. (2)** Quality improvement is an ongoing process of studying and improving healthcare processes. *Coordinated Care*
- 149. (4)** Delegation has become a vital management tool for nursing's success as a pivotal healthcare team member to ensure quality care, utilize staff appropriately and support cost effective healthcare. *Coordinated Care*
- 150. (1)** Patient supervision in this case can be challenging. When dealing with a confused and wandering patient, the nurse's priority is to ensure safety. If the environment is supportive, a personal alarm may allow the patient safe, personal freedom while at the same time alerting staff that the patient is up and moving. The alarm system does not decrease a requirement for supervision. *Coordinated Care*
- 151. (2)** Personal style potentially impacts communication styles which is a key in any relationship. The ability and experience of the supervisee will contribute to the supervisee's trust in terms of knowing what can be expected with this person's performance. Physical distance may complicate or decrease the ability for interaction. Other relatives working in the facility should not have anything to do with supervisory relationships. *Coordinated Care*
- 152. (3)** Crises are a failure of the usual coping mechanism to handle the current situation. Crises have common elements that are useful to know for intervention. Crises are resolved in approximately six weeks with the desired outcome of the client either returning to the prior level of functioning or a higher level. *Psychosocial Integrity*
- 153. (1)** During crisis intervention the precipitating event is explored. The client's needs and activities that threaten those needs are considered. Needs that may be threatened include self-esteem, role mastery, dependency and biological function. *Psychosocial Integrity*
- 154. (2)** The best assessment for elder abuse is a specific, non-threatening question. *Psychosocial Integrity*
- 155. (1)** Requirements for reporting elder abuse vary by state, but in all states the nurse is protected from prosecution unless the nurse knew the report was false. *Psychosocial Integrity*
- 156. (2)** Clients with bipolar disorder need to be hospitalized immediately if they may be a danger to themselves or others, or if they are psychotic. Family and friends must be taught symptoms that indicate someone with bipolar disorder may attempt suicide. *Psychosocial Integrity*
- 157. (1)** Hospitalization is usually not required for generalized anxiety disorder unless the client has suicidal thoughts, delusions, or difficulty providing self-care. Generalized anxiety disorder often occurs in tandem with other psychological disorders, some of which alone or in combination can cause suicidal intent or a desire to inflict harm on oneself. In such cases, emergency intervention is necessary. *Psychosocial Integrity*
- 158. (3)** According to Maslow physiological needs are the most basic as they maintain/sustain life of the organism; thus need to be considered priority. *Coordinated Care*
- 159. (2)** is correct. The ethical decision making process is similar to the nursing process. The first step is to collect and analyze information or data, which parallels assessment in the nursing process. The second step of ethical decision making is to identify options or consider an alternative which is the step of planning in nursing process. In ethical decision making, once options are identified to potential consequences of the plan need to be thought through. The next sequential step of ethical decision making is making a decision which follows the implementation step of nursing process. *Coordinated Care*
- 160. (4)** Measurements that fall between the 5th and 95th percentiles represent normal growth for most clients. The weight and height chart is done on each child to help determine growth patterns. *Health Promotion and Maintenance*

- 161. (3)** To assess nutritional patterns, the nurse obtains a dietary history, using a 24-hour diet recall, 3-day or 7- to 14-day dietary inventory, food frequency form, or similar tool. In using this tool, the client writes down all foods consumed; this provides an opportunity for the nurse to analyze the client's intake and make plans to teach a healthy diet, if called for. *Health Promotion and Maintenance*
- 162. (4)** Vitamins are essential for metabolism and are necessary body maintenance. Vitamins are water-soluble (B Complex and C) or fat-soluble (A, D, E, and K). *Health Promotion and Maintenance*
- 163. (1)** Culture influences conceptualization of health and illness. This (culture) varies from family to family, region to region. *Health Promotion and Maintenance*
- 164. (2)** According to Pender, in stimulus control, attention is directed toward changing the antecedents rather than the consequences of behavior as addressed in operant conditioning. This method of behavior control suggests that by changing events that precede undesirable behavior, it is possible to decrease or eliminate such action and increase successful behavior. Stimulus control concentrates on arranging environmental cues to promote only the desired behavior. The original Health Belief Model and Pender's Health Promotion Model agree that cues are important factors in promoting health behavioral change. *Health Promotion and Maintenance*
- 165. (3)** According to Pender's Health Promotion Model, nurses should work with families to accomplish stimulus control by accurately identifying under what conditions desirable behavior occurs more frequently, and under what circumstances undesirable behavior is prompted. Nurses should offer instruction on how to develop sensitivity to appropriate cues and counsel families on ways to facilitate opportunities for encountering those that are appropriate. Behavioral cues may be taken from a variety of sources. Examples of possible sources include contact with health care professionals, significant others, and the communication media, or visual stimuli from the environment such as viewing others participating in the target activity. In addition to environmental cues, nurses can further influence desired action by encouraging families to develop a positive set of internal cues such as "feeling good," or an increased sense of self-esteem. External cues, such as having family member or friend invite you to an aerobic exercise class, can be combined with internal cues, such as remembering feeling more energetic after exercise sessions. Multiple cues potentiate each other. *Health Promotion and Maintenance*
- 166. (2)** The recommendation is that women age 40 and over have annual mammogram screening regardless of family history. *Health Promotion and Maintenance*
- 167. (2)** The client should not apply preparations to the breast, nipple, or underarm on examination day. The procedure uses low-dose x-ray technology and takes about 15 minutes. There is some discomfort due to compression of the breast. *Health Promotion and Maintenance*
- 168. (4)** Younger women have more dense tissue and are poor candidates for mammography. The recommendation is that younger women perform breast self exam monthly and seek out a clinical breast exam at least every 3 years or annually if indicated by family history of breast cancer. *Health Promotion and Maintenance*
- 169. (2)** The structured model of communication consists of sender, receiver, message, context, and feedback loop. Feedback refers to the receiver's verbal and/or behavioral response. Options 1 and 4—The client's verbal and nonverbal behavior does constitute a response. Option 3—The nurse is the sender of the message. *Psychosocial Integrity*
- 170. (1)** The data on assessment supports the nursing diagnosis of impaired social interaction. Some characteristics of this diagnosis include having limited communication with others and verbalizing negative feelings of insecurity around other people. Option 3—No information on nurse-client relationship; option 4—personal or artistic talent is not necessary to participation. *Psychosocial Integrity*
- 171. (1)** Healing of the relationship requires honesty and expression of concerns. This must occur between the parties involved in the relationship. The actions in options 2 and 3 do not help resolve feelings. Option 4 does not encourage honesty and expression of concerns. *Psychosocial Integrity*
- 172. (3)** Exploration of why the plan was unsuccessful must be accomplished first. The nurse looks first at his or her own actions to document the appropriateness. It is important for the dying client to have continuity of care. *Psychosocial Integrity*

- 173. (4)** Gallstone formation is Cholelithiasis; obstruction is caused by gallstones, which causes aggregation of substances in the bile; the gallstones may remain in the gallbladder or enter the cystic duct; they then obstruct the flow of bile into and out of the gallbladder; supersaturation sets the stage for cholesterol crystal formation and aggregation into “macrostones”; main symptom is pain. *Physiological Adaptation*
- 174. (4)** Short-term starvation is several days of total dietary abstinence or deprivation; Glucose is the preferred energy for cells; once all available energy has been absorbed from the intestine, glycogen in the liver is converted to glucose through glycogenolysis, or the splitting of glycogen into glucose. This process peaks within for to eight hours after glycogenolysis, and gluconeogenesis in the liver begins by the formation of glucose from noncarbohydrate molecules. Both of these processes deplete stored nutrients and thus cannot meet the body’s energy needs indefinitely. Proteins continue to be catabolized in gluconeogenesis to a minimal degree to provide carbon for the synthesis of glucose; adequate ingestion of appropriate nutrients is the obvious treatment for starvation. Starvation caused by chronic disease, long-term illness, or malabsorption is treated by enteral or parenteral nutrition. *Physiological Adaptation*
- 175. (2)** Jaundice is a yellow discoloration of the skin, mucous membranes, and sclera of the eyes, caused by greater than normal bilirubin in the blood; symptoms: nausea/vomiting, abdominal pain, dark urine; liver diseases, biliary obstruction, and hemolytic anemias; hemolytic jaundice—the red blood cells hemolyze and an excess of bilirubin results from the breakdown of released hemoglobin. *Physiological Adaptation*
- 176. (3)** Melena, or black, tarry stools, is a sign of bleeding high in the GI tract. The action of the digestive enzymes turns bright red blood to black and tarry before defecation occurs; the ulceration is thought to be caused by hydrochloric acid and pepsin secretions of the stomach and by intestinal juice, including bile, that is regurgitated through the pyloric sphincter; the gastric mucosa becomes irritated by this bile-containing secretion and the lesion develops; symptoms—nausea, vomiting, abdominal pain. *Physiological Adaptation*
- 177. (2)** Small-cell lung cancer has a poor prognosis because it is rarely diagnosed in a limited and localized state. Even with treatment the client has only a 20 percent chance for 2-year survival. At advanced stages most clients die within 6 months. The 5-year survival rate depends on the type of lung cancer (non-small-cell cancer has a somewhat better 5-year survival rate) and stage (cancer is easier to treat in an earlier stage when the cancer is localized). Usually by the time a lung tumor is detected on x-ray, about 75 percent of the disease course has elapsed. Eighty-seven percent of lung cancer clients die within 5 years. *Physiological Adaptation*
- 178. (4)** Dry desquamation of the skin; external radiation therapy side effects are: nausea, fatigue, malaise, skin irritation, wet desquamation, diarrhea. *Physiological Adaptation*
- 179. (3)** Skin markings over the treatment area should not be washed off for the duration of the therapy unless special permission is given because they are important reference marks for the radiation beams. The area should be left open to air, but sunlight should be avoided. The skin should not be massaged, and lotions, cosmetics, and powder should not be applied. These interventions will reduce the problems associated with dry desquamation of the skin. *Physiological Adaptation*
- 180. (4)** In filing out an incident report the nurse should avoid attempting to document the cause of the incident. The report does require what the nurse saw, or heard; an appropriate patient assessment; and a description of the immediate interventions at the time of the incident. *Coordinated Care*
- 181. (3)** In signing witness the nurse is indicating that consent was obtained without coercion. Answer(s) 1, 2, and 4 are incorrect. The nurse is not in a position to judge adequacy of explanatory information, nor she can measure comprehension to determine it sufficient. A client’s understanding of post procedure recovery is only one piece of the information. They also need to understand the nature of the procedure, its risks, potential benefits, and probable outcomes. *Coordinated Care*
- 182. (2)** OBRA (The Omnibus and Reconciliation Act) was passed in 1987 as a major impetus for nursing home reform. It imposes regulatory oversight in the nursing home industry, driven by poor quality of care concerns. While the regulations imposed by OBRA standardize care to some extent based on goals, nursing homes continue to run as independent businesses. OBRA did not deal with funding problems; rather quality of care. The demographics, while defining the significance of nursing home difficulties is not a major thread driving the need for reform. *Coordinated Care*

- 183. (4)** Organ donation may be made from either living or deceased donors. *Coordinated Care*
- 184. (2)** D5W contains 5 grams of dextrose per 100 milliliters. A liter bag contains 1000 milliliters. Thus, if there are 5 grams of dextrose in 100 milliliters there is 50 grams in 1000 milliliters. *Pharmacological Therapies*
- 185. (3)** These antecubital veins are commonly used in adult IV therapy. The site in option 1 is generally reserved for very ill patients requiring monitoring. The leg vessel in option 2 is not a common IV site in adults. It is used more often in children and neonates. Scalp vein usage is common in neonates. *Pharmacological Therapies*
- 186. (4)** Nonsteroidal anti-inflammatory drugs (NSAIDs) inhibit cyclooxygenase, an enzyme that catalyzes the first step in the synthesis of prostaglandins from arachidonic acid and other 20-carbon fatty acids. NSAIDs have no effect on arachidonic acid. Sterol is a steroid-based alcohol found in cell membranes of eukaryotes. Cholesterol is a sterol. Sterol is not responsible for prostaglandin production. Thromboxane is derived from prostaglandins. If prostaglandin production is blocked thromboxane production cannot occur. *Pharmacological Therapies*
- 187. (3)** A drug is transformed from one form into another when it is metabolized. During this process the drug is converted to its metabolites by an enzyme-catalyst reaction. Drug absorption is the passage of a drug from its site of administration into the circulation. Distribution is the process where drugs are transported by the circulatory system to tissues and organs. Elimination is the removal of the drug from the body. Elimination occurs primarily via the renal and hepatic system. *Pharmacological Therapies*
- 188. (1)** These medications increase inotropy (myocardial contractility) thus improving cardiac output, renal blood flow, and glomerular filtration. Sodium and water restriction are indicated in patients with CHF, but these are not drug therapies. Antiarrhythmics are only used to treat CHF caused by rhythm disturbances. Aspirin is utilized for its antiplatelet effect, not to treat CHF. *Pharmacological Therapies*
- 189. (3)** High alert drugs can cause considerable morbidity and mortality if administered incorrectly or in toxic amounts. Cost and effectiveness do not make certain drugs high alert medications. High alert drugs are to be used cautiously in all patients, not one specific group. *Pharmacological Therapies*
- 190. (2)** To gain a client's trust, respect must be conveyed even if there is disagreement with the belief expressed. Introductions and further assessment are important but ineffective if respect is not conveyed. Notifying the physician does not have priority at this time. *Psychosocial Integrity*
- 191. (1)** A nursing diagnosis of spiritual distress is appropriate for this client. Therefore the most important goal is to restore his spiritual well-being. Relationships and walking are not related to this diagnosis. The rosary is a Catholic aid to prayer. *Psychosocial Integrity*
- 192. (3)** Oligodendroglia cells produce lipid complements that form myelin. Ependyma produce CSF. Microglial cells are part of the phagocytic system. Astrocyte maintains the chemical environment of cells. *Psychosocial Integrity*
- 193. (2)** Kinesthetic refers to awareness of the position and movement of body parts. Tactile—perception to pain or discomfort; perception to heat, cold, or pain in the limbs; numbness or tingling in extremities. Visceral refers to any large organ within the body. *Psychosocial Integrity*
- 194. (4)** Crises are acute (not chronic) events that will be resolved in one way or another within brief time periods. Crises are usually precipitated by a specific identifiable event. Crises for one person may not be perceived as a crisis by another person. *Psychosocial Integrity*
- 195. (4)** A dispositional crisis is a response to an external situational crisis. External anger at work is the dispositional crisis displaced to his wife through abuse. An anticipated life transition crisis is a crisis that is normal in the life cycle; transitional is one which the person has no control. Developmental crisis occurs in response to triggering emotions related to unresolved conflict in one's life. This is called developmental crisis based on Freudian psychology. Psychiatric emergency crisis is when the individual's general functioning has been severely impaired and the individual has been rendered incompetent. *Psychosocial Integrity*
- 196. (3)** Reactive obesity occurs when an individual uses excessive eating to cope with stress and anxiety. Developmental obesity results from overfeeding in childhood. There is no evidence in Joan's history of any underlying medical condition or of therapy with any medication that might produce weight gain. *Psychosocial Integrity*

- 197. (1)** Teaching alternative stress reduction techniques that may be substituted for overeating most directly addresses the goal of replacing compulsive eating with a constructive anxiety-releasing activity. *Psychosocial Integrity*
- 198. (3)** The team of professionals dealing with a client in a health care agency (whether it is inpatient, outpatient, or another agency) should all be involved in the planning for discharge for the client from their agency. *Coordinated Care*
- 199. (4)** Managed care is a broad term which describes networks of providers who contractually agree to provide health care services for particular patient groups; it may be available in many different healthcare delivery sites including private physician's offices, skilled nursing facilities, acute care hospitals and others as long as the providers belong to the network. Fee-for-service care is care which has a set price (not negotiated) charged based on the provider's rates or charges. *Coordinated Care*
- 200. (3)** Hepatitis B immune globulin must be administered within 12 hours in addition to the vaccine. The MMR does not have a relevance for hepatitis B nor does Hib which refers to the haemophilus influenza type B vaccine administered at 2 months of age. *Health Promotion and Maintenance*
- 201. (4)** Rubella vaccine is administered to women who are rubella nonimmune during the postpartum period. Rubella vaccine is contraindicated in pregnancy. *Health Promotion and Maintenance*
- 202. (1)** Rubella vaccine administration is recommended to women who are rubella nonimmune because of the potential detrimental effects to the fetus if a woman is exposed to rubella during pregnancy. If the client is immune, the vaccine is not required and merely requesting the vaccine is not grounds to administer the vaccine. *Health Promotion and Maintenance*
- 203. (4)** Depending upon the needs, problems, and desired goals and outcomes of the client would designate whether group therapy with family is necessary. Options 1, 2, and 3 all pertain to the client's learning needs/characteristics. *Psychosocial Integrity*
- 204. (3)** Clients with mental illness and their families bear most of their burden of their condition. The NAMI is an important self-help/support group for both the client and support person(s). It is a group that advocates for people with mental illness; improving access to treatment services; and all of the major areas depicted in options 1, 2 and 4. *Psychosocial Integrity*
- 205. (2)** A depressed person avoids recognition of painful feelings by withdrawing. Clients often reject the overtures of the nurses and appear not to respond to nursing interventions. Understanding this reduces frustration. An awareness of the risk factors for depression, a comprehensive biopsychosocial assessment, and history of illness and past treatment are key to formulating a treatment plan and to evaluating outcomes. Individuals experiencing depression have often withdrawn from the daily social activities such as engaging in family activities, attending work, and participating in community activities. Nurses are challenged to help the patient balance the need for privacy with the need to return to normal social functioning. *Psychosocial Integrity*
- 206. (3)** A therapeutic relationship is person, client-focused, and aimed at realizing mutually-determined goals. Establishing and maintaining a therapeutic nurse-patient relationship is key to successful outcomes. Nursing interventions that foster the therapeutic relationship include being available in times of crisis, providing understanding and education to patients and their families regarding goals of treatment, providing the encouragement and feedback concerning the patient's progress, providing guidance in patient's interpersonal interactions with others and work environment, and helping to set and monitor realistic goals. *Psychosocial Integrity*
- 207. (4)** Assessment of the interaction process gives the nurse an overview of the family process. To learn specifically about the interaction process, the nurse should inquire about of communication. Therapeutic communication promotes understanding and can help establish a constructive relationship between the nurse and the client. Nurses need to respond not only to the content of a client's verbal or non-verbal message(s) but also to the feelings expressed. It is important to understand how the client views the situation and feels about it before responding. Option 1 provides less specific information about their relationship, while options 2 and 3 are irrelevant. *Psychosocial Integrity*
- 208. (2)** One agent must be totally eliminated before beginning to eliminate the second agent. Options 1, 3, and 4— This will likely trigger seizures. The physician would have no way of knowing lack of which agent caused the seizures. *Pharmacological Therapies*

- 209. (4)** Monoamine oxidase destroys serotonin. MOA inhibitors prevent serotonin destruction. Concurrent administration of a selective serotonin reuptake inhibitor (SSRI) can result in toxic levels of serotonin. MOAIs do not cross react with beta-lactam antibiotics, calcium channel blockers, or hypercholesterolemia agents. *Pharmacological Therapies*
- 210. (2)** Naloxone is a opioid antagonist. It combines competitively with opiate receptors and blocks or reverses the action of narcotic analgesics. Naloxone has virtually no pharmacologic effects in the absence of opioids. *Pharmacological Therapies*
- 211. (1)** Acetaminophen is a non-narcotic analgesic manufactured entirely in the laboratory. This agent has minimal effects on peripheral prostaglandin synthesis and therefore, has no anti-inflammatory effects. Acetaminophen has no anticoagulant effect. Acetaminophen is an anti-pyretic which decreases fever by a hypothalamic effect. *Pharmacological Therapies*
- 212. (1)** Bilateral chest rise. Both sides of the chest rises, which is normal and indicates adequate respiratory mechanism. Tachypnea is a breathing rate that is faster than the normal rate. Bradypnea is a breathing rate that is slower than the normal rate. Agonal breathing is a gasping type of respiration that has no pattern and occurs very infrequently. It is often a sign of impending cardiac or respiratory arrest. *Physiological Adaptation*
- 213. (4)** Assessing the airway of an older patient is often difficult because of arthritic changes in the bones of the neck. As one grows older, less air enters and exits the lungs, less gas exchange occurs, the lung tissue loses its elasticity, and many of the muscles used in breathing lose their strength and coordination. *Physiological Adaptation*
- 214. (3)** Although rhythm must be observed, it is not included under the *quality* of breathing. Quality includes breath sounds (diminished, unequal, or absent?), chest expansion (inadequate or unequal?), and depth of respirations (labored, increased respiratory effort, use of accessory muscles). *Physiological Adaptation*
- 215. (3)** An unresponsive patient with shallow, gasping breaths with only a few breaths per minute (agonal respirations) is clearly breathing inadequately. You must provide artificial ventilation with supplemental oxygen preferable via pocket face mask. *Physiological Adaptation*
- 216. (1)** Phenytoin is an antiepileptic drug in the hydantoin class. Infants with fetal hydantoin syndrome present with a variety of abnormalities. Most notable are digit and nail hypoplasia, unusual facies, and growth and mental deficiencies. Additional craniofacial defects are common. In addition, hirsutism, short neck, and rib anomalies may also be present. Similar craniofacial features are associated with prenatal exposure to carbamazepine (Tegretol), valproic acid (Depakote), primidone (Mysoline), and phenobarbital. The infant is not at risk of seizures because of the maternal seizure disorder. Neither of these agents cause omphalocele malformation. Phenobarbital withdrawal symptoms (restlessness, hypertonicity, diarrhea, vomiting, poor suck) and seizures in patients with seizure disorder present at 3–7 days after birth due to the long half-life of the drug. *Pharmacological Therapies*
- 217. (2)** These side effects are frequent occurrences with analgesic medication administration. Narcotics are noted to cause constipation. 1: Analgesics relieve pain promoting restful sleep. The manifestations in options 3 and 4 are not common with analgesic administration. *Pharmacological Therapies*
- 218. (2)** UTIs cause a burning sensation when one voids. Toxins of the bacteria cause an irritation of mucosal membrane leading to pain or burning on voiding. *Basic Care and Comfort*
- 219. (2)** Adolescent pregnancy is viewed as particularly problematic because of the vulnerability of and lack of resources of the mother. Not surprisingly, pregnancy is the chief cause of women leaving school. Within marriage, early pregnancy (within the first two years) detracts from marital adjustment. *Health Promotion and Maintenance*
- 220. (4)** The physical health of mother and child is a major issue, documented in obstetrical and perinatal studies. Birth intervals of between two and four years and a maternal age in the 20s are the most favorable factors for reducing maternal and infant mortality and morbidity. *Health Promotion and Maintenance*
- 221. (3)** Optimal family size, spacing, and timing of births also reduces infant mortality. *Health Promotion and Maintenance*



- 222. (4)** The rate of planned pregnancies is growing, as is the number of women or couples who are using contraceptives. Forty-five states as well as the District of Columbia, have enacted legislation allowing teenage girls under the age of 18 to obtain contraceptives without parental consent. Yet a large proportion of sexually active adolescents and young adult women are not receiving family planning services. Furthermore, contraceptive use is known to be less among black and Hispanic teenagers (72 percent and 53 percent, respectively) at first intercourse than among white teenagers (83 percent). *Health Promotion and Maintenance*
- 223. (3)** Recognize factors that facilitate or impede the process of inspection. Compare the purpose of palpation with its appropriate technique. Compare the purpose of percussion with its appropriate technique. Compare the purpose of auscultation with its appropriate technique. Identify appropriate equipment and associated techniques for measuring vital signs. Identify appropriate equipment and associated techniques for measuring height and weight. *Health Promotion and Maintenance*
- 224. (2)** Percussion is the use of sound waves to detect body tissue density. Percussion tone is loud over air, medium loud over fluid, and soft over solid areas. Proceed from areas of resonance to areas of dullness. Firmly place middle distal phalanx on surface. Snap wrist and tap tip of the same finger of opposite hand onto placed finger. First percussion is used to elicit liver, kidney, and gallbladder tenderness. *Health Promotion and Maintenance*
- 225. (3)** Unlike the physician, the nurse takes a health history to assess the impact of illness on the client and family and to identify educational and discharge planning needs. The nursing health history takes a holistic view of the client and provides insight into actual and potential problems. This allows the nurse to develop an individualized care plan and provides an opportunity for client teaching. *Health Promotion and Maintenance*
- 226. (2)** Body Image is more important when strong emotions are attached to the perceived body. Adolescence is a time when everyone wants to be liked by everyone. Acne on the face causes much embarrassment and feelings of not “fitting in.” Body image for teens reflects their peer group attitudes and the desire for belonging. *Physiological Adaptation*
- 227. (2)** Written sources reflect that disfigurement or scarring of the body can profoundly affect the person’s body image. The personal strengths an individual recognizes, develops and uses are powerful but subjective determinants of self-concept. Any alteration of body image can cause changes in self-concept. *Physiological Adaptation*
- 228. (3)** Increased blood pressure and decreased pulse rate may indicate increase intracranial pressure (ICP). Further assessment and treatment must be undertaken promptly; any changes in responsiveness should receive consideration; decreased responsiveness may indicate increased ICP; a positive glucose reading would indicate the presence of CSF and a possible leak; if the skin were pale and cool or moist, it would indicate active bleeding and development of shock. The temperature may be normal in this patient. Although the nurse would monitor for an increase in temperature, it would not require immediate attention. *Physiological Adaptation*
- 229. (2)** When the right ventricle fails, congestion of the viscera and peripheral tissues results because the right side of the heart cannot adequately empty its blood volume. In addition, the heart cannot accommodate all the blood returning from the venous circulation. *Physiological Adaptation*
- 230. (2)** Serum creatinine is a constant measure of muscle waste product. In renal insufficiency, creatinine would increase as it is normally secreted by the kidney. A BUN measures the kidney’s ability to remove waste products. A rising BUN may indicate renal dz as cr and BUN trend in the same direction. *Basic Care and Comfort*
- 231. (4)** Coughing and laughing increases abdominal pressure above the bladder causing leakage of urine secondary to stress of increased abdominal pressure on bladder. *Basic Care and Comfort*
- 232. (2)** The femoral vein is used for right-sided heart catheterization. The femoral and brachial arteries are used for left-sided heart catheterization. *Reduction of Risk Potential*
- 233. (3)** Due to the dye used for the cardiac catheterization, poor renal function is a contraindication. Acute myocardial infarction used to be a contraindication, but is no longer, as physicians can determine whether further intervention is needed immediately for such a client when doing a catheterization. The other options are not contraindications for the test. *Reduction of Risk Potential*
- 234. (1)** The heel is a common site for capillary puncture in the newborn, not the other areas. *Reduction of Risk Potential*

- 235. (3)** A durable power of attorney for health care designates legal authority for health care decision making to a specific individual. Decision making is to be guided by the living will. Answer(s) 1 and 2 are incorrect because the patient has not designated authority for financial decision making via a Durable Power of Attorney for Finance. Choice 4 is incorrect because legal authority is delegated by the Power of Attorney for Healthcare. *Coordinated Care*
- 236. (1)** The nurse's statement conveys her personal opinion based on her experience. Answer 2 is incorrect. Professional values are shaped by education and professional standards of practice which the nurse did not convey. Answer 3 is incorrect. Ethical values are based on beliefs regarding right and wrong. Answer 4 is incorrect. Moral values are based on sociocultural influences. *Coordinated Care*
- 237. (3)** is correct if the patient seeks your input and understands that it is your personal opinion only. Choices 1, 2 and 4 are incorrect as a professional nurse you must assist the person *Coordinated Care*
- 238. (2)** Advocacy involves helping not only those who cannot make decisions for themselves, but emphasizes support in decision-making so that patients have the information necessary to make informed decisions regarding treatments, costs, care needs, and risks of treatment. *Coordinated Care*
- 239. (2)** The correct sequence of the case management process is assessment, planning, implementation, coordination, monitoring, and evaluation of care. *Coordinated Care*
- 240. (4)** Meals on Wheels is the community provider of nutritional meal assistance. The local VNA provides skilled therapeutic services, hospice provides individuals with terminal illnesses with therapeutic care and assistance at the end-of-life, and AARP is an organization of older adults which provides education, insurance, information services and political action for seniors. *Coordinated Care*
- 241. (3)** The steps in Case Management are assessment, planning, implementation, coordination, monitoring, and evaluation. *Coordinated Care*
- 242. (4)** Standards of professional care, protocols for healthcare delivery, clinical guidelines and pathways, law, and facility protocols all guide case management processes. *Coordinated Care*
- 243. (3)** The "Patient's Bill of Rights" describes rights to privacy and confidentiality, the right to refuse to participate in research, the right to continuity of care, and the right to refuse treatment. *Coordinated Care*
- 244. (2)** The "Patient's Bill of Rights" describes the right of the patient to refuse to participate in research without the fear of loss of care by the health care team. He will still be cared for by physicians and nurses on the team, and other treatment options may be offered. The costs of research are commonly at least partially paid by the research study. *Coordinated Care*
- 245. (2)** Organizational theory is a group of related concepts, principles, and hypotheses that is used to explain components of organizations and how they behave. The theory may or may not provide a structure, help to define the dysfunction found in a family, or define outcomes of effective functioning. *Coordinated Care*
- 246. (3)** Motivation may be providing incentives to achieve outcomes or a state of mind from which a person views a task or goal, and is an important aspect of assisting a client in achievement of goals. *Coordinated Care*
- 247. (1)** Any strategy for task completion should be flexible. The most important task should be worked on as the top priority. Written notes of things to be completed assist in decreasing memory lapses. Accepting assignments which the nurse manager is not capable of completing leads to frustration and poor work performance. *Coordinated Care*
- 248. (4)** Ricin effects begin 1–12 hours; Ricin is a toxin isolated from castor beans; Ricin is a potent toxin that can be isolated from the "mash" that remains after castor beans are processed to make castor oil. Two to four castor beans contain enough Ricin to kill an adult. Ingestion of one castor bean can be lethal to a child; Ricin causes tissue necrosis, pneumonia, internal bleeding, and vascular collapse. Ricin is not volatile, therefore, secondary inhalation is not a hazard. However, skin contact should be avoided, and the patient should be washed with diluted bleach solution, soap and water. *Safety and Infection Control*
- 249. (3)** Many times in medical teaching-learning situations, the identity of the patient is known through the presentation information. When a patient's identity is known, the teaching-learning process may still occur while maintaining the confidentiality of the information presented and the learner need not remove him/herself from this process. It is



important, however, to remember not to continue the spread of the information through discussions where information may be dispersed publicly. It is also important to appropriately shred written documents which may carry information that may be identified as belonging to a specific patient. *Coordinated Care*

- 250. (4)** The signs and symptoms of small pox are similar to those of chicken pox. In chicken pox, the rash appears first on the trunk and spreads to the extremities. In smallpox, the rash begins on the extremities and spreads to the trunk. *Safety and Infection Control*
- 251. (2)** The wound care nurse will be important in this patient's recovery in assisting with regimens specific to healing venous ulcers in a diabetic. A physical therapist may later be called upon to assist with mobility concerns, along with a DME specialist if walkers or assistive devices are needed. A neurologist would be needed only if neurological disease were suspected. *Coordinated Care*
- 252. (4)** Family members can place bells on interior gates, high locks or alarms on exterior doors, and alarms and locks on gates surrounding their home to alert them to the whereabouts of a patient with diminished mental capacity. Fastening ties to a lap robe may appear less confining to a patient and family while maintaining a forgetful patient securely in a chair. A mitten with the thumb sewn closed may sufficiently reduce manual dexterity to prevent removal of the tubing. Covering tubing with towels or strategic placement of a pillow may deter some patients. The use of upper and lower siderails must be evaluated for their potential to increase risk of injury if a patient climbs over the rail. Introducing siderails as an aid for turning and positioning them in bed may overcome initial resistance in accepting them. To alert family members that a patient in danger of falling is attempting to get out of bed unassisted, a string of bells may be fastened to the lower portion of the top cover. A baby monitor and closed circuit tv are other methods to detect movement and sounds, thereby enabling caregivers to respond promptly. *Safety and Infection Control*
- 253. (1)** Primary prevention is the health care practices and lifestyle behaviors that help healthy people stay healthy. The goal of secondary prevention is to help those with chronic illness manage their disease and avoid complications. Tertiary health care is helping clients adapt to losses or complications that result from a disease or chronic illness. Primary preventative care is not covered by all insurance plans. *Coordinated Care*
- 254. (1)** Kanski and co-workers found that family members of patient being restrained in acute care settings had a variety of negative reactions to this intervention. The authors give examples of family members' statements such as these. "She didn't do anything she's tied up." "It made me mad—They just walked in, put on the restraint and never said a word." "She didn't need to be restrained. She couldn't move her right arm and uses her left hand to position her right arm. My mother started to cry when they tied her wrist." *Safety and Infection Control*
- 255. (4)** A quality indicator is a quantitative measure of an important aspect of care that determines whether standards are being met. It is a standard of performance. On a med-surg unit specific care indicators could include: medications errors, incisional wound infections, post-op incidence of pneumonia. The number of re-admissions with a primary diagnosis of CHF would be more likely to be institutional focused due to the high volume potential exceeding that of the unit activity in caring for those patients. *Coordinated Care*
- 256. (3)** More time is required in the orientation phase for clients who have serious, persistent mental illness. Clients with frequent hospitalizations also require more time in the orientation phase. *Psychosocial Integrity*
- 257. (2)** Delegation is an effective method of workload distribution, as tasks are shared within a team *Coordinated Care*
- 258. (4)** The termination phase is the most difficult phase, but is also an essential part of the relationship. Tasks during this phase include evaluating progress, exploring feeling of rejection, making referrals if necessary, and relating the feelings generated by the anticipated loss to other losses the client has experienced. *Psychosocial Integrity*
- 259. (2)** After formulating specific diagnoses as part of the planning process, the nurse uses critical thinking skills to establish priorities by ranking them in the order of their importance. *Coordinated Care*
- 260. (2)** Clients may display covert anger as termination of the relationship is approaching by arriving late, missing meetings, and engaging in superficial talk. When the nurse recognizes this happening, the nurse can help the client identify and explore the feelings behind the behavior. *Psychosocial Integrity*
- 261. (1)** The nurse should provide opportunities for the students to develop their own values, beliefs and attitudes about sexuality but should not determine for the student what those should be teaching "appropriate" values. Options 2, 3, and 4 are all goals of a comprehensive sex education program. Many times students have not gotten

accurate information about sexuality because too few parents discuss sexual issues with their children and many schools focus only on biological facts to avoid controversy. The comprehensive program will help students develop positive views of sexuality, gain factual information about sexual health and the skills to maintain it, and provide students with the opportunity to acquire decision-making abilities related to sexual issues. The goal is not to just provide facts because knowing about sexual issues doesn't necessarily change sexual behavior. *Health Promotion and Maintenance*

- 262. (2)** All of the options represent real findings of a recent CDC youth risk behavior surveillance. While the surveillance included other behaviors, of the ones provided, choice 2 represents the highest priority for education, with nearly 1/2 of the students not using a condom during their last sexual intercourse. That is still way too many students at risk for sexually transmitted infections and unwanted pregnancy. So, increasing the use of condoms becomes the number 1 priority of these findings. The second priority, established by option 3, would be to decrease alcohol and drug use since nearly 1/3 of the students used during their last sexual intercourse. Alcohol and drug use increases the risk potential of adolescents because they are more likely to have unprotected sex and not use condoms. Additionally, there is an increased risk of HIV transmission from contaminated needles. Option 1 is also a risky behavior but because it involves few students doesn't carry the same priority for intervention. Option 4 is the lowest priority of the findings listed, even though it is an ominous finding for the students it represents. All of these issues can be addressed in a comprehensive sex education program, but since the question asked to establish priorities related to the findings, the order of priority becomes option 2, 3, 1, and 4. *Health Promotion and Maintenance*
- 263. (3)** Adolescence is actually the peak age for practice and participation in sports activities. Most injuries occur during practice and can be related to trying to make the team, lack of use of protective equipment and heat to name a few. Choices 1, 2 and 4 are all developmental characteristics that increase the risk of injury. Adolescents have a strong need for peer approval and may attempt unsafe activities if their peers encourage them to. Adolescents also reach the legal age to drive and many engage in risk taking driving behaviors, especially if with their peers. Adolescence is also the time when they are allowed to use more complex tools for recreation or jobs. With that use comes increased risk of injury. *Coordinated Care*
- 264. (4)** A small child's foot experiences rapid growth between the ages of 2–3 and they should have their foot measured for new shoes at least every 3 months. Signs that they need a new shoe include curled toes, redness and irritation of the skin. High top shoes are not necessary for support of the ankle or foot. They simply help keep the shoe on the infant's foot as it is not as easily removed. The child's shoe should be soft and be able to be flexed in the middle with pressure applied by the thumb and index finger. At the time of purchase there should be 1/2 inch between the longest toe and the shoe. A shorter distance does not allow for sufficient growth before the next shoe is purchased. A longer distance will impede the child's balance while trying to walk. *Coordinated Care*
- 265. (4)** Documented decisions made before illness strikes and communicated with a family and caregivers help to make the decision easier for organ donation at the time of death. *Coordinated Care*

# NCLEX-RN Practice Test 2

**Directions:** For each of the following questions, select the choice that best answers the question or completes the statement.

1. Which of these self-care measures would the nurse include when teaching a pregnant woman about exercise?
  1. Check your pulse while exercising and slow your pace if your pulse rate reaches 160.
  2. You may exercise to the point of fatigue but should avoid exhaustion.
  3. Avoid exercising in the supine position after the first trimester.
  4. After exercise relax in the hot tub or sauna for 10 minutes.
2. Which of these strategies would the nurse include when teaching a pregnant woman about sexual activity?
  1. "You should avoid sexual intercourse during the last 6–8 weeks of your pregnancy."
  2. "After your fourth month of pregnancy you should place a pillow under your right hip during intercourse."
  3. "Your orgasms will become less intense during the last weeks of pregnancy."
  4. "Many women experience decreased sexual desire during their second trimester."
3. When a pregnant couple is over the age of 35, the nurse should expect the couple to demonstrate which of these behaviors?
  1. increased financial concern related to costs associated with the birth
  2. increased confidence related to previous childbirth experiences
  3. increased anxiety of physical risk related to maternal age
  4. moderate anxiety related to uncertainty about fetal well being
4. Which of these strategies would the nurse include when planning care for a pregnant woman who has a decreased MSAFP (maternal serum alpha-fetoprotein), an increase in hCG (human chorionic gonadotropin), and a decreased Estriol level?
  1. Refer to the physician.
  2. Tell the woman to increase her folic acid intake.
  3. Refer for amniocentesis.
  4. Order a plasma glucose level.
5. The parents of a preschool child have been given instructions about the Denver II. Which of these statements, if made by the parents, would indicate that they correctly understood the teaching?
  1. "This test will tell me whether or not my child's IQ is normal."
  2. "This test will tell me what developmental tasks my child can do today."
  3. "This test will measure my child's development."
  4. "This will let me know if my child's development is normal or not."
6. When teaching the parents of toddler-age children about expected developmental milestones, at which age should the nurse tell the parents most children are walking?
  1. 12 months
  2. 15 months
  3. 18 months
  4. 24 months
7. If a school age child's growth and development is within normal range, which of these developmental stages would a nurse expect to identify?
  1. trust
  2. industry
  3. initiative
  4. autonomy

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8. When teaching parents about the pros and cons of their children sleeping with them, which of the following information should the nurse give the parents?
1. "If you give your child more attention during the day they will not want to sleep with you at night."
  2. "Sleeping with parents can contribute to Sudden Infant Death Syndrome."
  3. "Children should never be allowed to sleep with their parents."
  4. "You could be accused of sexual abuse if you allow your child to sleep with you."
9. The teaching plan for a client with hair loss secondary to chemotherapy should include which of the following instructions on obtaining a wig?
1. "Wait until your hair comes out before purchasing a wig."
  2. "Treatments are tax-deductible, but not the wig."
  3. "You can purchase a wig at the American Cancer Society."
  4. "A beautician should be able to give you tips on how to vary the style."
10. A client who is receiving chemotherapy has a nursing diagnosis of disturbed body image related to changes in appearance secondary to chemotherapy. Which of these nursing measures should be included in this client's care plan?
1. Discourage use of turbans or scarves for hair loss.
  2. Explain hair grows back like it was before chemotherapy.
  3. Let friends and relatives initiate offers of assistance.
  4. Allow significant others to share their feelings and fears.
11. Which of the following nursing measures should be included in the care of a client who has experienced the loss of a body part or function?
1. Explain to the client what the loss should mean to them.
  2. Use role playing to assist with sharing feelings.
  3. Encourage the client to "get over it" and assume self-care.
  4. Expect the client to respond to the loss with acceptance.
12. Which of these changes in her body should the nurse prepare a woman who is pregnant for the first time to experience during the first trimester?
1. striae development on the breasts
  2. presence of a tingling sensation
  3. leakage of colostrum
  4. appearance of secondary areola
13. Which intervention by the nurse can be used to minimize swelling at a puncture site for cerebral angiography?
1. Apply ice.
  2. Apply heat.
  3. Apply gauze.
  4. Apply alcohol.
14. Which of the following is a common side effect of a lumbar puncture?
1. Muscle aches
  2. Headache
  3. Fatigue
  4. Confusion
15. What position is commonly prescribed after a client has received a lumbar puncture?
1. prone
  2. side-lying
  3. supine
  4. Trendelenburg
16. Which of the following arterial blood gas values represents metabolic alkalosis?
1. pH = 7.30, pCO<sub>2</sub> = 50 mm Hg, HCO<sub>3</sub> = 24 mEq/L
  2. pH = 7.20, pCO<sub>2</sub> = 36 mm Hg, HCO<sub>3</sub> = 18 mEq/L
  3. pH = 7.10, pCO<sub>2</sub> = 50 mm Hg, HCO<sub>3</sub> = 24 mEq/L
  4. pH = 7.60, pCO<sub>2</sub> = 38 mm Hg, HCO<sub>3</sub> = 30 mEq/L

- 17.** Which of the following arterial blood gas values represents metabolic acidosis?
1. pH = 7.30, pCO<sub>2</sub> = 50 mm Hg, HCO<sub>3</sub> = 24 mEq/L
  2. pH = 7.20, pCO<sub>2</sub> = 36 mm Hg, HCO<sub>3</sub> = 18 mEq/L
  3. pH = 7.80, pCO<sub>2</sub> = 37 mm Hg, HCO<sub>3</sub> = 32 mEq/L
  4. pH = 7.60, pCO<sub>2</sub> = 38 mm Hg, HCO<sub>3</sub> = 30 mEq/L
- 18.** Which of the following arterial blood gas values represents respiratory alkalosis?
1. pH = 7.30, pCO<sub>2</sub> = 50 mm Hg, HCO<sub>3</sub> = 24 mEq/L
  2. pH = 7.20, pCO<sub>2</sub> = 36 mm Hg, HCO<sub>3</sub> = 18 mEq/L
  3. pH = 7.80, pCO<sub>2</sub> = 37 mm Hg, HCO<sub>3</sub> = 32 mEq/L
  4. pH = 7.60, pCO<sub>2</sub> = 38 mm Hg, HCO<sub>3</sub> = 30 mEq/L
- 19.** Which of the following is a sign or symptom of hypothyroidism?
1. weight gain
  2. weight loss
  3. diaphoresis
  4. palpitations
- 20.** Which of the following is a structure of the female reproductive system that functions to release oocytes?
1. vagina
  2. uterus
  3. ovary
  4. cervix
- 21.** Which of the following is a structure of the male reproductive system that functions to produce sperm?
1. penis
  2. testes
  3. scrotum
  4. urethra
- 22.** Following an above the knee amputation of a single leg, the nurse should teach the client wearing a prosthesis the following gait:
1. four-point gait.
  2. three-point gait.
  3. tri-point gait.
  4. swing-through gait.
- 23.** One of the purposes of mobility assistance devices is to:
1. provide for long-term rehabilitative care.
  2. relieve the family of having to transport the client.
  3. provide for greater mobility and independence.
  4. assist the client in greater speed of transport.
- 24.** When preparing a teaching plan for a client using a walker, the nurse should:
1. help the client obtain a “good” walker that the client desires.
  2. assist the client in correct and safe use of the walker.
  3. have the family works with the client for better confidence.
  4. take measurements of the client, including body weight, leg and arm length, and handgrip.
- 25.** The nurse is working in radiology with a client undergoing an intravenous pyelogram. Which of the following complaints by the patient is an abnormal finding?
1. thirst and feeling “worn out”
  2. frequent, loose stools
  3. feeling dizzy and warm with obvious facial flushing
  4. dyspnea and audible wheezing
- 26.** A urinalysis of a patient reveals a high bacterial count. Gantrisin is prescribed for the UTI. The teaching plan for a UTI should include all of the following except:
1. always wipe perineum back to front.
  2. consume 2000 cc of fluid daily.
  3. drink plenty of cranberry juice.
  4. explain the side effects of medication.

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**27.** Nocturia is best defined as:

1. total urine output of less than 30 cc/hr.
2. painful and difficulty voiding.
3. voiding more frequently than every 3 hours.
4. awakening at night to urinate.

**28.** Which of the following required activities is essential to maintaining mobility?

1. walking
2. sitting
3. bed rest
4. reclining

**29.** At which of the following ages does muscle tone and bone strength decrease?

1. 10–12
2. 14–18
3. 20–30
4. 40–60

**30.** Which of the following gait patterns is characteristic of a patient with Parkinson's Disease?

1. ataxic gait
2. spastic gait
3. waddling gait
4. festinating gait

**31.** A client who is recovering from a mastectomy is severely depressed. Which statement describes the purpose of bathing that is recognized as the most applicable and beneficial for this client?

1. promotes comfort and relaxation
2. promotes cleanliness and self-image
3. conditions the skin and promotes ROM
4. stimulates respirations and circulation

**32.** Choose an appropriate nursing action when giving perineal care to a female.

1. Wear sterile gloves.
2. Wash from the pubis toward the anus.
3. Wash from dirty to clean.
4. Do not use soap.

**33.** A nurse is assigned to take two clients' vital signs, complete a focus assessment, provide hygiene care, administer meds, and complete a dressing change for a client with an abdominal wound. Which task will have priority with this assignment?

1. Take vital signs and provide hygienic care on the first client.
2. Administer medications to the clients.
3. Complete the dressing change.
4. Take vital signs on the two clients.

**34.** When teaching a client about using spermicides, which of the following information should the nurse include?

1. Suppositories are effective immediately upon insertion.
2. Insert the spermicide low in the vagina.
3. Maintain a supine position once the spermicide is inserted.
4. Spermicides require a prescription.

**35.** The nurse would plan to teach a client who uses condoms as contraception to do which of the following?

1. Use Vaseline jelly as a lubricant.
2. Use natural skin condoms for protection of STDs.
3. Apply the condom to the flaccid penis.
4. Withdraw the penis from the vagina while still erect.

**36.** When instructing a client on the use of a female condom, the nurse should include which of the following?

1. The greatest protection is obtained when combined with a male condom.
2. The female condom is designed for repeated use.
3. The female condom can be inserted up to eight hours prior to intercourse.
4. The inner sheath is lubricated with a spermicide.

- 37.** When obtaining a health history from a client wishing to be fitted for a diaphragm, which information should a nurse recognize as most critical?
1. smoker over the age of 35
  2. history of toxic shock syndrome
  3. client is lactating
  4. non-compliance with oral contraceptives
- 38.** Which of the following clients is *most* at risk of developing gallbladder disease?
1. a 45-year-old Asian man
  2. a 45-year-old Caucasian woman
  3. a 30-year-old Caucasian woman
  4. a 50-year-old Hispanic man
- 39.** Which of the following foods are most likely to exacerbate acute cholecystitis?
1. beans
  2. apples
  3. lettuce
  4. bacon
- 40.** A Hispanic client with hepatitis tells the nurse he would like to take milk thistle for his condition. What is the appropriate response of the nurse?
1. Tell him the request is inappropriate.
  2. Notify the physician of his request.
  3. Tell him that herbs are not effective.
  4. Instruct him he needs a prescription.
- 41.** Your patient is seen in the doctor's office and diagnosed with the cardiac glycoside digoxin (Lanoxin) toxicity. Which of the following assessment data supports this diagnosis?
1. dyspnea and pulmonary edema
  2. visual disturbances, nausea, and vomiting
  3. dry mouth, sleep disturbances, and constipation
  4. hypertension and flushing
- 42.** The loop diuretics such as furosemide (Lasix) and bumetanide (Bumex) can be ototoxic. This effect is enhanced when certain antibiotics are given concomitantly. An example of an antibiotic that could potentiate ototoxicity is:
1. an aminoglycoside antibiotic such as gentamicin (Garamycin).
  2. a beta-lactam antibiotic such as ampicillin (Omnipen, Polycillin).
  3. a cephalosporin antibiotic such as cefoxitin (Mefoxin).
  4. a macrolide antibiotic such as azithromycin (Zithromax).
- 43.** Your patient is being treated with the potent loop diuretic bumetanide (Bumex). He is complaining of intermittent intense flank pain. You expect:
1. acute pancreatitis, a common side effect of bumetanide administration.
  2. nephrocalcinosis with some red blood cells in the urine.
  3. hypoglycemia secondary to the increased insulin production caused by this drug.
  4. muscle cramping secondary to the hyperkalemic effect of this drug.
- 44.** The nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin, ibuprofen, and naproxen are nonselective cyclooxygenase (COX) inhibitors. Adverse effects of these drugs are common in which system?
1. central nervous system (CNS)
  2. respiratory system
  3. gastrointestinal system (GI)
  4. cardiovascular system (CV)
- 45.** The guidelines for acute pain management by the AHCPR cite nonpharmacological interventions to be appropriate for clients who meet the following criteria:
1. may benefit from avoiding drug therapy and expresses anxiety or fear about what is going to happen.
  2. wants to cope with the pain so that hospital release will be faster.
  3. wants cutaneous stimulation of the body with a mechanical vibration.
  4. have prolonged teaching to use this type of therapy.

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- 46.** An anxious-appearing client with acquired immunodeficiency syndrome (AIDS) tells the nurse that he has a burning sensation with shooting pain to both feet that is excruciating in nature. How would the nurse interpret this client's report?
1. The client is experiencing neuropathic pain to the distal lower extremities.
  2. Psychogenic pain to both feet is accompanied by an anxious appearance.
  3. There is referred pain described as excruciating to the bilateral feet.
  4. Severe phantom pain is present to the feet which is resulting in anxiety.
- 47.** A male client is very anxious about the pain he will experience postoperatively. Which of the following interventions would be most effective in initially helping him deal with this fear?
1. Teach him relaxation techniques such as deep-breathing and guided imagery.
  2. Explain the availability of pain medications after surgery.
  3. Demonstrate the various positioning techniques that promote post-op comfort.
  4. Distract the client from discussing pain by focusing on surgical preparation.
- 48.** The Dietary Supplement and Health Education Act states that:
1. herbs, vitamins, and minerals may be sold with their therapeutic advantages listed on the label.
  2. the Food and Drug Administration must evaluate all herbal therapies.
  3. herbs, vitamins, and minerals may be sold as long as no therapeutic claims are made on the label.
  4. in conjunction with the Food and Drug Administration, all supplements are considered safe for use.
- 49.** What foods have the highest content of potassium and are included in a client's care plan when at risk for hypokalemia?
1. potatoes, apricots, broccoli
  2. carrots, squash, and okra
  3. canned soups and milk
  4. whole grain products, apples
- 50.** Identify the objective data to be documented after assessing the nutritional status of a newly admitted client.
1. eats three meals per day
  2. has a hearty appetite, likes all food
  3. understands requirements of a well-balanced diet
  4. average weight for height, age, and body build
- 51.** A recent diagnosis of cancer has caused a patient severe anxiety. The plan of care should include:
1. teaching the stages of grieving.
  2. providing distraction during time of stress.
  3. teaching chemotherapy aspects.
  4. encouraging verbalization of concerns regarding diagnosis.
- 52.** A patient has undergone "a classic cholecystectomy." To promote comfort when coughing, the nurse should teach the patient to:
1. lean forward when coughing.
  2. lie down on left side when coughing.
  3. sit up and support abdomen with pillow.
  4. dangle feet on the side of the bed before coughing.
- 53.** A patient is undergoing chemotherapy following a laryngectomy for laryngeal cancer. The patient begins complaining of a sore mouth. The nurse should assess for:
1. Xerostomia.
  2. Halatosis.
  3. Stomatitis.
  4. Dysgeusia.
- 54.** The nurse is assessing the skin of a patient. A lesion is noted on the upper back. It is 7mm across, variegated color, with a notched border. The RN knows that this is:
1. pigmented nevus.
  2. actinic keratosis.
  3. suspicious mole.
  4. seborrheic keratosis.



- 55.** While assessing a patient who has been burned, the RN notes neck and facial burns, singed eyebrows and nasal hair, and hoarseness. The nurse knows this patient has likely suffered:
1. an inhalation burn.
  2. full thickness burns.
  3. partial thickness burns.
  4. burns requiring an escharotomy.
- 56.** Prioritize the following problems for a patient admitted with a severe burn today: a. acute pain; b. ineffective airway clearance; c. fluid volume deficit; d. hypothermia.
1. a, b, c, d
  2. b, d, c, a
  3. c, b, a, d
  4. b, c, d, a
- 57.** Lab tests used to help diagnose pancreatitis include:
1. amylase, lipase.
  2. lipase, bilirubin.
  3. bilirubin, amylase.
  4. amylase, glucose.
- 58.** Which of the following describes the stages of domestic violence in an intimate relationship?
1. happiness, crisis, angry outburst, intervention
  2. honeymoon period, escalation of stress, outburst, reconciliation
  3. acting out and making up
  4. peace and calm, angry outburst, peace and calm, denial
- 59.** Which of the following statements is correct regarding rape?
1. Most rapes are reported.
  2. Legally, a woman can be raped by her spouse.
  3. Prosecution and conviction for rape is easy.
  4. The most common location of rape is the victim's own home.
- 60.** Which statement by the spouse of a client being treated for depression indicates that teaching was effective?
1. "I need to continue to bring my wife to therapy even though the medicine has helped her not feel as depressed."
  2. "My wife is feeling much better now. She will only need to take the medicine on days that she is feeling sad."
  3. "My wife will need to take this medicine for the rest of her life."
  4. "When she is finished with this counseling, my wife will not be depressed again."
- 61.** A client reports that she gains weight and feels sad and sleepy every winter. She asks what she can do to prevent this from happening this year. The nurse's response is based on the knowledge that:
1. seasonal affective disorder is a learned behavior and changing one's thought pattern is effective.
  2. in-depth psychotherapy is the most effective method to treat seasonal affective disorder.
  3. seasonal affective disorder has been improved by one hour per day of winter light or using light-box therapy.
  4. the first recommended treatment is a selective serotonin reuptake inhibitors with light therapy as a second option.
- 62.** Which of the following interventions is most likely to enhance the community's response to sexual trauma?
1. increasing the police force
  2. providing post trauma counseling free of charge
  3. establishing a Sexual Assault Nurse Examiner Program
  4. providing emergency room care by board certified gynecologists
- 63.** A child states, "I have a problem, but you have to promise not to tell anyone." The nurse's best response would be:
1. "I can keep a secret. You can tell me."
  2. "I will need to tell someone if you are being hurt."
  3. "I will have to tell your parents anything that you tell me."
  4. "Do not tell me anything you do not want others to know."

- 64.** When assessing a 4-year-old female child according to Freud's psychosexual theory, which of the following findings would the nurse expect to identify?
1. repressed sexual impulses
  2. Oedipus complex
  3. child's focus is on genitals
  4. sense of pleasure derived from oral stimulation
- 65.** Using behavioral theories of sexual development, which of the following factors would the nurse expect to most impact a child's sexual development?
1. sexual abuse
  2. physiological responses to learned stimuli
  3. psychological responses to a reinforcement event
  4. measurable sexual behavior
- 66.** A client who is receiving an SSRI (selective serotonin reuptake inhibitor) would be at risk for developing which of the following sexual side effects?
1. anorgasmia
  2. increased libido
  3. premature ejaculation
  4. priapism
- 67.** When obtaining a health history from a female client who is concerned about contracting HIV/AIDS, which of the following sexual practices would a nurse recognize as having the greatest risk for infection?
1. unprotected heterosexual sexual contact
  2. intravenous drug use
  3. homosexual (Lesbian) sexual contact
  4. protected heterosexual sexual contact with five life-time partners
- 68.** When assessing the sexual functioning of a postmenopausal woman, a nurse should expect to obtain which of these findings?
1. increased elasticity of the vaginal walls
  2. decreased vaginal lubrication
  3. no change in sensitivity of the breast
  4. increased blood flow to the vagina
- 69.** When assessing a client from a functional family, a nurse should expect to identify which of the following characteristics?
1. Children are responsible for activities advanced for their age.
  2. Differences between family members are discouraged.
  3. Emotional contact is maintained across generations.
  4. Commonly use third-party to resolve problems.
- 70.** All of the following characteristics, if identified in a client's family, would indicate to the nurse that pathology exists within the family except?
1. presence of a "super spouse" and a dependent, compliant spouse
  2. positive emotional climate valued more than what "should" be done
  3. overly close three generations in which lines of authority are blurred
  4. child who has poor peer relations at school while parenting younger siblings
- 71.** When the nurse is documenting a family history by using a genogram, which of the following should be included?
1. living first and second degree relatives
  2. health status of index patient and ill relatives
  3. current household configurations
  4. four generations of family members
- 72.** When family members use emotional isolation or geographical distance to deal with intense family conflict the nurse documents this behavior as?
1. differentiation
  2. family projection process
  3. triangulation
  4. emotional cutoff
- 73.** Which of the following nursing diagnoses is most appropriate for the client who has recently had surgery for repair of a mandibular fracture?
1. activity intolerance
  2. imbalanced nutrition
  3. bowel incontinence
  4. impaired mobility

- 74.** What percentage of clients experiences the complication of phantom limb sensation after an amputation?
1. 10 percent
  2. 30 percent
  3. 60 percent
  4. 80 percent
- 75.** Which of the following statements by a client going home after a below the knee amputation indicates further need for teaching by the nurse?
1. "I will check my stump daily for signs of irritation."
  2. "I will only wear a residual limb sock on the stump."
  3. "I will change the residual limb sock weekly."
  4. "I will perform range of motion daily."
- 76.** Two people have been in a car accident and have similar injuries. According to the transaction-based model, their degree of stress from the accident would be:
1. completely individual based on previous experience.
  2. extremely similar since they had the same stimulus.
  3. the identical physiologic alarm reaction.
  4. different depending on their external resources and support levels.
- 77.** Although clients may exhibit calm behavior, physical evidence of stress may still be manifested by:
1. constricted pupils.
  2. dilated peripheral blood vessels (flush).
  3. hyperventilation
  4. decreased heart rate.
- 78.** Holistic Health includes in Mental Health:
1. proper clothing, nutrition, exercise.
  2. herbal teas, special foods, acupuncture.
  3. concentration, relaxation, social systems.
  4. moxibustion, special foods, relaxation.
- 79.** Factors that can affect activity of the client in Mental Health are:
1. temperature, safety, values about health and exercise.
  2. depression, chronic stress, fatigue.
  3. depression, osteoporosis, congenital heart disease.
  4. stress, temperature, availability of a gym.
- 80.** Which of the following defense mechanism is being displayed when the patient with a substance abuse problem tells the nurse that the reason he does not attend group therapy is that he has nothing in common with the other patients?
1. substitution
  2. sublimation
  3. denial
  4. passivity
- 81.** A patient is placed on a higher than usual dose of an opioid analgesic for pain management of osteosarcoma. He asks the nurse if he is becoming a drug addict. An appropriate response by the nurse is:
1. "Yes, the drugs you are taking are highly addictive, but you can be detoxed later."
  2. "Opioids have never been shown to produce addiction in those who take them only for pain."
  3. "Addiction and tolerance are not the same. Your body needs more medicine now and it is important not to undertreat your pain."
  4. "If you feel you are becoming addicted, switch your medicine to Tylenol."
- 82.** A client who is a Jehovah's Witness needs a transfusion of packed red blood cells but refuses the transfusion. What is the appropriate response of the nurse?
1. Have the client sign a refusal form.
  2. Give the transfusion anyhow.
  3. Lecture the client on the need for blood.
  4. Berate the client for such beliefs.
- 83.** What is the maximum amount of time that packed red blood cells may be administered?
1. 2 hours
  2. 3 hours
  3. 4 hours
  4. 5 hours

- 84.** Which of the following actions by the nurse will prevent air embolism in clients with central venous access lines?
1. using the head-up position during line insertion
  2. clearing the line of air prior to insertion
  3. using gravity intravenous fluid administration
  4. using bandaid dressing after line removal
- 85.** A client is being assessed for treatment of dual diagnoses of bipolar disorder and alcohol abuse. The nurse will recommend which as the best treatment program?
1. cognitive therapy because both problems involve irrational thinking
  2. a serial program of substance abuse treatment and then treatment for the bipolar disorder
  3. attend two separate programs for substance abuse and the bipolar disorder at the same time
  4. an integrated program that treats both substance-related and the mental health disorders
- 86.** A client in an acute care facility states that someone is trying to poison him. An initial short-term goal would be:
1. client will take responsibility for decision making.
  2. client will recognize discrepancies between reality and delusion.
  3. client will discuss consequences of delusions.
  4. client will discuss delusion with nurse.
- 87.** An Emergency Department nurse is preparing to assess a male client who reported being sexually abused by a woman. The nurse's best response would be:
1. "You are too strong to be abused by a woman."
  2. "What did you do to provoke the woman?"
  3. "Please describe what happened."
  4. "Is your preference heterosexual, homosexual or bisexual?"
- 88.** An Emergency Department nurse is caring for a client who reported being raped. The nurse's priority action would be:
1. complete the mandatory reporting form.
  2. notify the local rape crisis center.
  3. maintain "chain of command" of all physical evidence.
  4. identify and treat all client physical injuries.
- 89.** A 45-year-old male client has a history of celiac sprue with five hospitalizations over the last 10 years. His last hospitalization was over a year ago. He is able to suppress his symptoms by eating a well-balanced gluten-free diet. Dietary management of this disease corresponds with which level of prevention?
1. primary prevention
  2. secondary prevention
  3. tertiary prevention
  4. health promotion
- 90.** When a physician orders an arterial blood gas, which blood vessel is an appropriate one to use to obtain the specimen to send to lab?
1. cerebral artery
  2. radial artery
  3. carotid artery
  4. ulnar artery
- 91.** While working in the university healthcare clinic, the nurse encounters an 18-year-old female student requesting birth control pills. The nurse teaches the student about contraceptives and sexually transmitted diseases. What statement from the student would indicate an understanding of the information the nurse provided.
1. "I don't need to worry about getting pregnant even if I miss a pill."
  2. "You can only get an STD if you have vaginal intercourse."
  3. "I must use a condom or barrier method to keep from getting an STD."
  4. "Birth control pills are effective in preventing pregnancy and STD's."

- 92.** A 55-year-old female client recently had a bone scan. She was found to have a decrease in bone mass. What should the nurse recommend the client do to prevent the development of osteoporosis?
1. Increase her calcium intake.
  2. Decrease activity to prevent bone loss.
  3. Stop exercising to prevent bone fractures.
  4. Decrease sodium intake.
- 93.** Which component of health history usually is longer for a pediatric client than an adult?
1. status of physiologic systems
  2. past health status
  3. family health status
  4. developmental considerations
- 94.** Patricia Brown, age 75, is admitted to the medical-surgical unit because of uncontrolled diabetes. When assessing this elderly client, the nurse should place extra emphasis on which component of the health history?
1. developmental considerations
  2. childhood illnesses
  3. biographic data
  4. role and relationship patterns
- 95.** Which documentation statement suggests an abnormal finding for Ms. Graves?
1. tympanic membranes shiny and pink
  2. anteroposterior diameter 1:2
  3. right breast slightly larger than left
  4. bowels sounds auscultated in all four quadrants
- 96.** A client is being scheduled for her first mammogram. It is important for the nurse to tell the client which of the following?
1. The procedure will take approximately 1 hour.
  2. Do not apply deodorant, cream, or powder to breast, nipple or underarm on examination day.
  3. The exam will not result in any discomfort.
  4. The procedure uses ultrasound technology.
- 97.** The term DNR refers to:
1. CPR only.
  2. a decision regarding care in the acute care hospital.
  3. use of artificial feeding and hydration.
  4. use of medications and treatments used for sustaining life or comfort goals.
- 98.** Advocacy involves all of the following except:
1. maintenance of patient rights in clinical trials.
  2. care only for those who cannot defend themselves.
  3. education of patients regarding treatment choices.
  4. discourages decision-making based on cost.
- 99.** A recently widowed 56-year-old patient is receiving dialysis and tells the nurse he does not like to cook for himself. As his case manager you would refer him to:
1. the local visiting nurses association.
  2. hospice.
  3. AARP.
  4. meals on wheels.
- 100.** The most effective method for decreasing the incidence of lead toxicity in children is:
1. continued legislative mandates regarding the content of paint and paint products.
  2. chelation therapy.
  3. prevention of exposure.
  4. screening all toddlers during well child examination.
- 101.** As the nurse manager plans for staffing for the pediatric unit, she knows which developmental accomplishment of the infant increases the risk for unintentional death and injury?
1. loss of the fear of falling
  2. fear of Strangers
  3. social Smile
  4. walking

- 102.** A 26-week pregnant client explains that she has had no fetal movement for several days. She works long hours standing in an assembly line in a chemical plant that manufactures insecticide. As you prepare the client for examination, she asks what you know about fetal risk and pesticides. You respond:
1. “Most of the so called fetal risk theories have been debunked by recent research.”
  2. “Let’s don’t discuss such depressing things right now.”
  3. “You need to wait and let the doctor discuss the risks with you.”
  4. “There is a link between pesticides and fetal harm. What do you know about it?”
- 103.** The nurse provides care to a client newly diagnosed with tuberculosis who is beginning antibiotics. Which of the following medication regimens will the nurse anticipate for this client?
1. A single drug (monotherapy) is common if the infection is mild.
  2. Because the mycobacterium grows slowly, duration of treatment will be 9–18 months.
  3. Medication will include the use of three anti-viral agents such as AZT, Saquinivir, Ritonavir.
  4. Typically the medication regimen will include 3 or 4 drugs such as Isoniazid, Rifampin, Pyrazinamide, Ethambutol.
- 104.** Rights of patients described in the American Hospital Association’s “Patient’s Bill of Rights” include all of the following except:
1. privacy and confidentiality.
  2. the right to refuse to participate in research.
  3. care without respect for continuity.
  4. the right to refuse treatment.
- 105.** The power a nurse exerts when he/she works to accomplish goals and effect change in an agency or in policy is considered what type of power?
1. political
  2. personal
  3. positional
  4. professional
- 106.** While attending closed medical case rounds you are given as a part of the teaching-learning process a detailed written case which is to be further discussed. In the course of the discussion, the identity of the patient becomes known to the group. You should:
1. dispose of any class notes in the regular trash.
  2. stop the discussion immediately once the identity of the patient is known.
  3. participate in the discussion while in class, but dispose of the case information in the shredded trash after the presentation.
  4. respect the patient’s confidentiality by leaving the presentation at the point at which the identity of the patient becomes known.
- 107.** You are caring for a patient with peripheral vascular disease and diabetes who has venous ulcers. You may expect the patient to be seen by:
1. physical therapist.
  2. wound care nurse.
  3. durable medical equipment (DME) specialist.
  4. neurologist.
- 108.** As a clinic nurse, one of your middle-aged patients tells you that she is concerned about her health as she wants to make changes to avoid and minimize health problems in the future. The focus of your patient teaching is on primary preventive care practices which:
1. helps healthy people stay healthy.
  2. help individual’s with illness avoid complications.
  3. help clients adapt to functional losses.
  4. are covered entirely by insurance plans.
- 109.** If the client is not allergic, what medication is the drug of choice for Methicillin Resistant *Staphylococcus Aureus*?
1. intravenous aqueous penicillin
  2. Mefoxin intramuscularly
  3. Vancomycin intravenously
  4. Rocephin intravenously

- 110.** Generally, which of the following disinfectants are used by the nurse for routine hand assepsis?
1. alcohol based hand rub
  2. betadine
  3. Benzalkonium Chloride
  4. soap and water scrub
- 111.** What are the Classifications of Restraints?
1. Behavioral and Medical/Surgical
  2. Behavioral and Safety
  3. Environmental and Medical
  4. Physical and Chemical
- 112.** “Environmental restraints” are:
1. temperature control.
  2. pollen control.
  3. barriers as large plants.
  4. dust control.
- 113.** Assessment of acute medical/surgical care clients with restraints should include all except:
1. skin and circulation.
  2. patient response.
  3. range of motion.
  4. number of restraints.
- 114.** The physician orders calcium chloride in 5 percent dextrose and 0.45 percent sodium chloride (D5/1/2NSS). What effect may saline solution have on calcium chloride?
1. It may increase the effects of calcium.
  2. It has little or no effect on the calcium additive.
  3. Calcium additives should always be added to IV solutions containing sodium chloride.
  4. Sodium encourages calcium loss; calcium should not be mixed with a saline solution.
- 115.** The best response by the nurse to an order (calcium IV) of IV saline would be:
1. explain to the client that she should not accept this intravenous fluid.
  2. suggest to the healthcare provider to change the IV order to 5 percent dextrose in water (D5W) and explain why.
  3. do nothing since this solution would not have any effect on the calcium chloride additive.
  4. report the healthcare provider to the chiefs of nursing and medicine.
- 116.** Lactated Ringer’s IV solutions has similar composition to:
1. white blood cells.
  2. plasma.
  3. body tissue.
  4. skin.
- 117.** These IV solutions are classified as:
1. colloids.
  2. crystalloids.
  3. lipids.
  4. blood products.
- 118.** A patient with multiple myeloma is admitted to the hospital with a pathologic fracture of the tibia and is ordered to be on bed rest. Which of the following nursing actions would be appropriate?
1. raising the head of the bed to a 10-degree angle
  2. turning the patient on her side once a shift
  3. having the patient fast before a scheduled x-ray
  4. accurate recording of fluid intake and output
- 119.** The nurse would give immediate consideration to which of the following assessment findings in a female patient with autoimmune thrombocytopenic purpura?
1. petechiae on the chest
  2. cold moist skin
  3. bruising on the arms
  4. heavy menstrual flow
- 120.** During the past three months, a boy who is 13 years old with hemophilia A has suddenly had an increased number of admissions for bleeding episodes. In planning for his discharge, the nurse should:
1. advise the patient to stop going to school.
  2. encourage him to depend on his parents to provide his care.
  3. question him and his parents about possible exposure to trauma.
  4. instruct his parents to give him aspirin for joint discomfort.

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- 121.** A patient newly diagnosed with Hodgkin's disease will most often report which of the following symptoms to the nurse when providing a history?
1. generalized pruritus
  2. petechiae across the back
  3. nausea and vomiting
  4. weight gain
- 122.** In 1900, communicable diseases were the leading causes of death in the United States. By 1000, epidemics that once ravaged entire populations ended. Which of the following is not a reason for the decrease in communicable diseases in the last century?
1. improved nutrition
  2. vaccines
  3. improved access to healthcare
  4. antibiotics
- 123.** Which of the following is not an outcome of infectious diseases?
1. increased mortality
  2. increased morbidity
  3. economic burden
  4. leading cause of death
- 124.** The epidemiological triad is:
1. the interaction of an agent, a host, and the environment.
  2. a natural history of disease model.
  3. a primary prevention model.
  4. primary, secondary and tertiary prevention.
- 125.** When family members arrive at the ED and are informed that a family member has died, the nurse responds with which of the following actions?
1. Offer to obtain a physician order for sedation.
  2. Volunteer details of the event leading to the death.
  3. Inform the family member that the patient has "passed on."
  4. Show acceptance of the deceased's body by touching when the family members view the body.
- 126.** The single most important factor in determining survival from cardiac arrest is:
1. nitroglycerin administration.
  2. training middle-aged and older people in CPT.
  3. early CPR.
  4. early defibrillation.
- 127.** When the nurse suspects that the aged patient admitted to the Emergency Room with areas of skin hemorrhage at various stages of resolution may be a victim of maltreatment, which of the following questions is phrased appropriately?
1. "Who has been hitting you?"
  2. "Where did you get those bruises?"
  3. "Has anyone failed to help you take care of yourself when you needed help?"
  4. "Do you have a balance problem?"
- 128.** When an unconscious client is admitted to the Emergency Room with known poisoning, and the nurse is assisting with gastric lavage, the nurse:
1. places the patient in a left lateral position with the head elevated 30 degrees.
  2. instills the antidote and then aspirates gastric contents.
  3. informs the conscious patient that an endotracheal tube must be placed prior to lavage.
  4. lubricates the tube with a water-soluble lubricant.
- 129.** A patient with hemophilia A lacks clotting factor VIII. Which blood product will this patient require?
1. albumin
  2. platelets
  3. cryoprecipitate
  4. granulocytes
- 130.** A newborn infant has rapidly rising indirect (unconjugated) bilirubin levels not responsive to therapy. To prevent brain damage (kernicterus) by the bilirubin the physician decides to perform an exchange transfusion. This procedure replaces the infant's blood containing bilirubin with donor blood without bilirubin. The product used for this procedure is:
1. whole blood.
  2. packed red blood cells.
  3. neutrophils.
  4. platelets.



- 131.** When administering multiple medications through a central venous access device (CVAD), the nurse flushes well between each medication. This action helps to prevent catheter occlusion from:
1. mechanical factors.
  2. venous thrombus development.
  3. precipitate formation.
  4. catheter migration.
- 132.** A patient asks a nurse what is the definition of a central venous access device (CVAD)? The nurse responds by saying:
1. "It is a convenient method of obtaining blood samples."
  2. "CVADs are part of long-term patient care."
  3. "It's a type of IV placed in a large blood vessel."
  4. "Placement of an IV device in a vein leading directly to the heart."
- 133.** Many patients who receive chemotherapy are tired and weak as a result of anemia. Anemia in these patients is a result of:
1. decreased erythropoiesis.
  2. iron deficiency.
  3. poor folic acid intake.
  4. exsanguination.
- 134.** The main goal of cancer chemotherapy is to:
1. limit the toxic side effects.
  2. attack the cancer as early as possible.
  3. cure or provide palliation if the cancer is not curable.
  4. provide the patient with a suitable quality of life.
- 135.** The potassium-sparing diuretic spironolactone (Aldactone) is not useful in emergency situations such as fulminant pulmonary edema because:
1. numerous patients have an allergic reaction to the drug.
  2. the onset of action is approximately 72 hours.
  3. the IV form of the drug is highly caustic to veins.
  4. more than one dose results in hyperkalemia and cardiac dysrhythmias.
- 136.** High potency topical corticosteroids should not be applied to which of the following areas?
1. legs
  2. arms
  3. face
  4. abdomen
- 137.** No infusion pump is available. The nurse needs to infuse IV fluid at 120 milliliters per hour. The IV administration set that is used will provide 1 milliliter of IV fluid for every 20 drops. The nurse should:
1. wait until an infusion pump is available.
  2. calculate, then infuse 40 drops of IV fluid per minute.
  3. check the drip rate with the pharmacy.
  4. hang the bag at "keep open" rate until an infusion pump is available.
- 138.** A hospital requires all IV doses of potassium chloride to be verified by two RNs prior to administration to a patient. What is the rationale for this policy?
1. To ensure this expensive medication is not wasted.
  2. To ensure adequate renal clearance.
  3. To ensure the correct dose of this narrow therapeutic index agent is administered.
  4. To ensure normal electrolyte balance.
- 139.** A patient with a serious GI illness has been receiving total parenteral nutrition (TPN) for 2 months. Today he reports right upper quadrant abdominal pain radiating to the right shoulder. The nurse would suspect:
1. cholecystolithiasis.
  2. myocardial infarction (MI).
  3. pneumonia.
  4. infection.
- 140.** One of the ingredients in total parenteral nutrition (TPN) fluid is a mixture of amino acids. This agent is added to TPN for what purpose?
1. as a buffer
  2. amino acids are utilized for anabolism
  3. to provide necessary trace elements.
  4. to maintain patency of the central venous catheter

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**141.** The only drug that is available to exert its therapeutic activity at the local site of action is:

1. hydrophilic.
2. pH neutral.
3. hydrophobic.
4. unbound from albumin .

**142.** Drugs that have a high hepatic extraction ratio:

1. have excellent oral bioavailability.
2. have significantly reduced bioavailability.
3. are unaffected by first pass effect.
4. require a reduction in dosage when administered orally.

**143.** The number of sleep cycles experienced by the usual sleeper of 8 hours is:

1. 1–2 cycles.
2. 2–4 cycles.
3. 4–6 cycles.
4. 7–10 cycles.

**144.** Which of the following is most important to know about sleep and health?

1. Eight hours of sleep is mandatory for health.
2. A regular sleep-wake rhythm is more important than the number of hours of sleep.
3. Sleep patterns depress protein synthesis.
4. Four hours is mandatory for good health.

**145.** Which of the following changes occurs during NREM sleep?

1. decreased systolic pressure, increased pulse rate, increased cardiac output
2. decreased systolic pressure, decreased pulse rate, and decreased cardiac output
3. decreased intracranial pressure, increased muscle tension, decreased growth hormone levels
4. increased systolic pressure, decreased intracranial pressure and increased cardiac output.

**146.** Potential quality indicators that may be the focus of unit-based quality improvement (CQI) activity on a med-surg unit are all of the following except:

1. medication errors.
2. incisional wound infections.
3. incidence of pneumonias post-operatively.
4. number of re-admissions with primary diagnosis of CHF.

**147.** The goal of delegation is:

1. staff satisfaction.
2. workload distribution
3. effective management
4. prioritizing patient care needs.

**148.** As the nurse assigned to a group of patients, you are responsible for supervising to ensure that patient care is completed according to the standard of care. This means that you:

1. must perform all the patient care yourself.
2. delegate tasks appropriately to other members of the health team, who are then responsible.
3. delegate tasks but maintain responsibility for the tasks being completed correctly.
4. delegate tasks, and at the point of delegation you are no longer responsible.

**149.** Methods of indirect patient supervision in an acute care setting are all of the following except:

1. telemetry.
2. bed alarms.
3. closed circuit monitoring (permission not required).
4. emergency announcements relayed over the loud speaker while the nurse is at lunch.

**150.** A client recently lost his job of 14 years and is facing a crisis. The nurse assesses the effect on role mastery by asking:

1. “In what areas of life do you feel successful?”
2. “Do you think you will not be able to earn enough money to pay your bills?”
3. “When did you first notice the symptoms?”
4. “Do you have any friends outside of work?”

- 151.** Sarah Morgan, age 77, is admitted to the medical-surgical unit because of uncontrolled diabetes. When assessing this elderly client, the nurse should place extra emphasis on which component of the health history?
1. developmental considerations
  2. childhood illnesses
  3. biographic data
  4. role and relationship patterns
- 152.** A woman has reported being ill and unable to work for the last three days. In exploring the precipitating event for this illness the nurse discovers the woman's car broke down the evening before the illness developed. The nurse's best response would be:
1. "Do you belong to an automobile club?"
  2. "That is bad luck. Who did you call to help you get to work?"
  3. "Do you think your car breaking down might have anything to do with your illness?"
  4. "How did you manage the stress of having to find a different way to work?"
- 153.** After giving birth, Mrs. Barber expresses concern that her baby daughter has "stork bites" (reddened areas at the nape of the neck). What should the nurse tell her about these skin lesions?
1. They are normal and disappear as the skin thickens.
  2. They are a sign of a common congenital anomaly.
  3. They result from trauma during delivery.
  4. They result from blocked apocrine glands.
- 154.** The nurse determines that a client is not receiving the necessary care required to maintain safety. The nurse would document that the care giver was performing which type of elder abuse?
1. negligence
  2. carelessness
  3. dereliction of duty
  4. psychological abuse
- 155.** What measure is necessary prior to photographing physical injuries in a competent, older adult who is believed to have experienced abuse?
1. consultation with the agency's legal representative
  2. acquisition of guardianship
  3. permission of the next of kin
  4. permission of the client
- 156.** A client with a diagnosis of schizophrenia is being discharged from an acute psychiatric hospital to the parent's home. Discharge plans include a day care program at the acute care hospital while the parents are at work. The father asks "I do not understand why the day care program was not used first. Why was my child hospitalized at all?" The nurse's best response would be:
1. "The hospitalization was to help you understand how sick your child is. Many people have difficulty understanding that mental illness is serious."
  2. "The hospital provided a secure environment for your child to stabilize and for you to make the necessary preparations in the home."
  3. "Your insurance covered the hospitalization so that is where your child was placed."
  4. "Having your child in the hospital provided the staff time to teach you how to provide the necessary care at home."
- 157.** A client with a diagnosis of obsessive compulsive disorder goes to a mental health center when the symptoms worsen. The client received counseling one year ago and has been maintained on medication. The client reports spending all his time editing a major report due at his work and cannot get anything else done. After assessing the situation the nurse recommends:
1. hospitalization until the behavior is modified.
  2. a residential program to provide a stress free environment.
  3. an adjustment in the medication dose.
  4. reducing stress by giving the responsibility for the report to someone else.
- 158.** Priority setting occurs during which step of the nursing process?
1. assessment
  2. planning
  3. intervention
  4. evaluation

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**159.** A nurse who supports a patient and family's need to make a decision that is right for them is practicing which of the following ethical principles?

1. autonomy
2. confidentiality
3. privacy
4. truthfulness

**160.** The client has several laboratory tests to determine wellness and healthy nutrition. A female adult who has iron deficiency anemia, falls below these laboratory values:

1. 10–20 percent (HCT).
2. 20–30 percent (HCT).
3. 17–18 percent (HCT).
4. 37–47 percent (HCT).

**161.** The specific purpose of data collection and analysis by the unit based Continuous Quality Improvement (CQI) team is to:

1. allow for accurate analysis of the appropriateness of care.
2. manipulate information about the key indicators to demonstrate that nursing goals are being met.
3. contribute to the large database required for the health care organization as a whole in meeting JCAHO's standards.
4. justify the need for unit staff.

**162.** During a preventive healthcare visit, an elderly patient states that she is getting shorter. When addressing general considerations, you should learn about her:

1. parent's heights.
2. usual water retention.
3. calcium intake.
4. usual weight and height.

**163.** Milestone achievements are data most likely to appear in the history of:

1. infants.
2. children.
3. adolescents.
4. young adults.

**164.** The major orientations to wellness, health promotion and illness are:

1. Health, Wellness, Illness Orientations.
2. Strategic Planning, Health, Illness Orientations.
3. Absence of Symptoms, Illness, Health Orientations.
4. Feeling-state, Symptoms, Performance Orientations.

**165.** Nurses applying intervention strategies should work with families to:

1. change all behaviors for positive health promotion.
2. choose behaviors with family to be changed.
3. change each individual member of the family to positive health behaviors.
4. schedule counseling sessions for the family to ventilate feelings.

**166.** For a family to be responsible for its own self-care, it needs:

1. understanding of own health status and steps to improve health.
2. understanding of home treatment, so emergency care is not sought.
3. know all self-care practices and solutions.
4. understanding of major literature on diseases and care.

**167.** A 55-year-old female is being referred for a colonoscopy screening. Which of the following instructions should the nurse expect to give the client?

1. The client can expect to take a bowel preparation the day before the procedure.
2. The client needs to eat a regular diet the day before the procedure.
3. The client needs to be on a clear liquid diet for 2 days prior to the procedure.
4. The client can expect to be under general anesthesia for the procedure.

- 168.** The nurse is teaching breast self exam to a client. What is the recommendation if a woman finds a lump in her breast during breast self exam?
1. The woman should change positions to determine whether she still feels the lump.
  2. The woman should wait until she performs breast self exam during the following month to determine whether she still feels the lump.
  3. The woman should check her breast again in 2 weeks to determine whether she still feels the lump.
  4. The woman should contact her physician to have her breast examined by a clinician.
- 169.** A client is worried about her abnormal annual pap smear result. She has been advised to return in six months for a repeat exam. The client asks the nurse "Do you think I have cancer?" The nurse's best response which of the following?
1. "The doctor would have told you if you had cancer."
  2. "Don't be silly, we get abnormal results all the time."
  3. "Abnormal results can sometimes indicate cancer."
  4. "It must be very concerning to have an abnormal test."
- 170.** An accurate statement about transference is:
1. Transference occurs when the client attributes thoughts and feelings toward the therapist that belong to a person in the client's past.
  2. Transference occurs when the therapist attributes thoughts and feelings toward the client that belong to a person in the client's past.
  3. Transference occurs when the therapist understands and builds a value system consistent with the client's value system.
  4. Transference occurs when the therapist recalls circumstances in his or her life similar to those the client is experiencing and shares this with the client.
- 171.** A nurse behavior that would not be considered a boundary violation is:
1. narcissism.
  2. controlling.
  3. genuineness.
  4. keeping secrets about the relationship.
- 172.** Grief is best described as:
1. a normal response to a significant loss.
  2. a mild to moderately severe mood disorder.
  3. the abnormal display of feelings associated with death.
  4. denial of the reality of the loss of a significant person, object, or state.
- 173.** Which statement would be evaluated as indicating successful mourning has taken place?
1. "She was so strong after her husband died. She never cried the whole time. She kept a stiff upper lip."
  2. "She was a wreck when her sister died. She cried and cried. It took her about a year before she resumed her usual activities with any zest."
  3. "You know, S. still talks about his mother as if she were alive today. . .and she's been dead for four years."
  4. "He never talked about his wife after she died. He just picked up and went on life's way."
- 174.** Irritable bowel syndrome can best be described as:
1. an inflammatory process.
  2. the result of longstanding GI disease.
  3. a functional disorder.
  4. an inherited trait.
- 175.** Which of the following nursing actions demonstrates the nurse's understanding of one of the primary complications for peritonitis?
1. Provide small, frequent meals.
  2. Frequently assess respiratory status.
  3. Assess skin integrity regularly.
  4. Evaluate stools for color and consistency.
- 176.** A client has just been diagnosed with closed-angle (narrow-angle or acute angle-closure) glaucoma. The nurse assesses the client for which of the following most common presenting symptoms of this disorder?
1. halo vision
  2. dull eye pain
  3. severe eye and face pain
  4. impaired night vision

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- 177.** The nurse notes a cloudy appearance to the lens of an 80-year-old client's eye. Which of the following additional assessment findings would help confirm the diagnosis of cataracts?
1. sense of curtain falling over the visual field
  2. persistent, dull eye pain
  3. loss of red reflex
  4. double vision
- 178.** What is the primary effect(s) of radiation therapy (head/neck) on nutritional status?
1. no effect if given an antiemetic
  2. weight gain
  3. increased appetite
  4. irritation, destruction of upper GI region
- 179.** A client receiving radiation therapy for a cancer tumor asked the nurse, "How is the radiation treatments done?" The nurse replied that:
1. the agents act on inhibiting DNA synthesis.
  2. the therapy can be either internal or external beam.
  3. the agents used kill all the cancer cells.
  4. the therapy of the beam of radiation is for the total body.
- 180.** A 67-year-old man is admitted to the hospital with a tentative diagnosis of bronchogenic carcinoma. His chief complaint is dyspnea and a chronic cough. The physician orders a sputum sample for cytologic testing. Important nursing implications involved with obtaining a sputum sample for cytology should include which of the following?
1. Obtain the specimen in the evening hours.
  2. Collect the specimen in the morning before the client eats and drinks.
  3. Have the client brush his teeth before collection of the specimen.
  4. Keep the client NPO for 24 hours before collection of the specimen.
- 181.** The nurse finds a client lying on the floor next to the bed. After returning the client to bed, assessing for injury and notifying the physician, the nurse fills out an incident report. Which of the following is the nurse's next action?
1. Give the incident report to the nurse manager.
  2. Place the incident report on the chart.
  3. Call the family to inform them.
  4. Omit mentioning the fall in the chart documentation.
- 182.** The nurse asks the client to sign a consent form before undergoing surgery. The client indicates that he was not told about the risks of the surgical procedure. Which of the following statements by the nurse is most appropriate?
1. "I can answer any of your questions."
  2. "Just sign the form now and I'll put a note on the chart that you have some questions."
  3. "Your doctor does a good job with this procedure. I've taken care of others that have had the same surgery and they've done very well."
  4. "I'll note your questions and contact the surgeon so that you can talk to him with him."
- 183.** A standard of care defines nursing practice expectations so that care is:
1. affordable.
  2. follows physician orders.
  3. is reasonably safe and appropriate.
  4. always consistent.
- 184.** You are caring for a dying woman whose family is being asked to make an organ donation. You know that:
1. the family may make the decision for the organ donation if there is no indication that woman was opposed to such a donation.
  2. the Uniform Anatomical Gift Act allows a person to make a decision before death regarding donation of their organ(s) at the time of death.
  3. documentation prior to becoming ill of the woman's desire for organ donation would assist the family in making a decision at the time of her death.
  4. all of the above.

- 185.** Hospitals have policies regarding the dextrose concentration of IV fluid that can be administered through a peripheral IV. This is necessary:
1. to increase patient comfort.
  2. to decrease the risk of bacterial growth.
  3. to maintain a normal blood glucose level.
  4. to decrease complications.
- 186.** The nurse initiates a new bag of IV fluid on a patient. What information should be documented in the patient's chart regarding this action?
1. date/time, type of fluid
  2. the appearance of the IV site
  3. the expiration date of the IV fluid
  4. that the IV fluid is clear without precipitate or particulate matter
- 187.** Venous vasodilators such as nitroglycerin reduce:
1. after-load.
  2. pre-load.
  3. myocardial contractility.
  4. sodium and water retention.
- 188.** The ability of a drug to dissolve and form a solution is called:
1. solubility.
  2. efficacy.
  3. potency.
  4. affinity.
- 189.** You are caring for a 67-year-old patient who has a history of a gastric ulcer. The physician wants to send her home on celecoxib (Celebrex) to treat rheumatoid arthritis. She asks you why she has to take a prescription medicine and wants to know why she can't take aspirin or ibuprofen (Motrin, Advil, Nuprin) that she can buy over-the-counter at the drugstore. What do you tell her?
1. She can substitute either aspirin or ibuprofen if she doesn't want to take a prescription medicine.
  2. Aspirin and ibuprofen do not relieve arthritis pain.
  3. Celecoxib does not cause adverse GI effects like aspirin or ibuprofen.
  4. Celecoxib is prescription-strength aspirin.
- 190.** Which class of diuretics is the most potent?
1. thiazides
  2. loop diuretics
  3. potassium sparing diuretics
  4. carbonic anhydrase inhibitors
- 191.** In order to provide culturally competent care, the nurse plans to provide a Chinese client with which of the following as the highest priority?
1. visit from a rabbi
  2. choice of diet
  3. written discharge instructions rather than oral
  4. teaching video instead of oral and written instructions
- 192.** A 4-year-old Mexican American client has recently been diagnosed with leukemia. What intervention would be appropriate when considering the client's culture?
1. Limit all visitors, including extended family.
  2. Encourage visits from extended as well as immediate family.
  3. Ban all visits from alternative healers.
  4. Make diet selections for the child and family.
- 193.** The purpose of the reticular activating system (RAC) in the sensory experience is to:
1. alert a person to more aesthetic stimulation.
  2. free the body to recognize all stimuli.
  3. maintain a sense of balance.
  4. remember information not immediately acted upon.
- 194.** Which of the following situations is considered to be sensory overload?
1. a person who is blind and deaf
  2. a person with post-operative pain for three weeks
  3. a prisoner in solitary confinement
  4. a client in ICU for 14 days
- 195.** A patient who has suicidal intentions would be experiencing which class of crisis?
1. psychiatric emergencies crisis
  2. developmental crisis
  3. anticipated life transition crisis
  4. dispositional crisis

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- 196.** A patient and his girlfriend have an argument. Which behavior by the patient would indicate he is learning adaptability to problem-solve his situational frustrations?
1. The patient says to the nurse, "Give me some of that medication before I end up in restraints."
  2. When the girlfriend leaves, the patient goes to the exercise room and punches on a punching bag.
  3. The patient says to the nurse, "I am going to dump that broad."
  4. The patient says to the girlfriend, "You had better leave before I do something I'm sorry for."
- 197.** A client is admitted to the nursing unit following a work-related injury sustained when the client failed to utilize safety devices available at the work site. The client tells the nurse that no one had ever said that the safety devices were important. In report to the next shift, the nurse would most appropriately state that the client is experiencing which of the following?
1. role ambiguity
  2. interpersonal conflict
  3. role mastery
  4. cultural conflict
- 198.** A nursing diagnosis formulated for a client was, "Ineffective individual coping related to feelings of loneliness and isolation as evidenced by use of overeating as a comfort measure." Which short-term goal is related to this nursing diagnosis?
1. Client will verbalize the importance of eating a balanced diet within two weeks.
  2. Client will identify two alternative methods of coping with loneliness and isolation within two weeks.
  3. Client will verbalize two positive things about herself within two weeks.
  4. Client will appropriately express angry feelings within two weeks.
- 199.** Mrs. Upham is being admitted to the hospital from the emergency room tonight. She will have emergent orthopedic surgery for a hip fracture first thing in the morning. When should discharge planning begin?
1. during the discharge planner's rounds after the surgery
  2. at the time of admission
  3. only after her needs can be assessed post-operatively
  4. at the time of discharge
- 200.** Your client is a member of a HMO. You know that:
1. the emphasis in this organization is on acute care in hospitals.
  2. there is an unlimited choice of providers of healthcare for this patient.
  3. the emphasis in the organization is on health maintenance and promotion.
  4. the patient was required to join this healthcare plan by her employer.
- 201.** In which of the following circumstances should the administration of the rubella vaccine be delayed until the 6-week postpartum follow-up visit?
1. if the client also requires administration of Rhogam
  2. if the client has had rubella
  3. if the client is rubella immun
  4. if the client is exhibiting mild cold symptoms
- 202.** Discharge teaching to a postpartum client who has just received the rubella vaccine should include which of the following precautions?
1. Avoid contact with individuals who are immunocompromised.
  2. Do not get pregnant within 3 months of receiving the vaccine.
  3. Do not get pregnant for 1 year following administration of the vaccine.
  4. Avoid contact with newborns.
- 203.** Which of the following is a common reaction to a DTP immunization?
1. headache
  2. photophobia
  3. drowsiness
  4. joint pain



- 204.** “Family Burdens” of persons with psychiatric disorders today place the client in the:
1. asylum.
  2. state Hospital.
  3. community.
  4. jail.
- 205.** You carefully listen to the concerns the family is expressing about their family member who suffers from alcoholism. What type of interventions are you using?
1. interventions to help solve family problems
  2. interventions to deal with destructive behaviors
  3. interventions to change family behaviors
  4. interventions to establish a nurse-family relationship
- 206.** The psychiatric clinical nurse specialist decides to use cognitive therapy techniques as she works with a client who has been diagnosed with anorexia nervosa. Which statement is consistent with cognitive therapy principles?
1. “You seem to feel much better about yourself when you eat something.”
  2. “Being thin doesn’t seem to solve your problems, since you are thin, now, and still unhappy.”
  3. “It must be difficult to talk about private matters to someone you just met.”
  4. “What are your feelings about not eating the food you prepare?”
- 207.** A prostitute, with HIV and severe complications, is being cared for on a medical unit. The nurse is seeking to develop a therapeutic relationship with the client. Which of the following statements best reflects the nurse’s attempt to support the client’s self-exploration?
1. “Don’t be embarrassed by your former occupation.”
  2. “Who do you go to for support?”
  3. “On what type of schedule do you think you could realistically eat your meals without being nauseated?”
  4. “The people who work here are professionals, and we don’t judge your past actions.”
- 208.** Approximately seventy percent of digoxin (Lanoxin) is excreted through the kidneys. Concurrent administration of which of the following medications could induce digoxin toxicity?
1. an aminoglycoside antibiotic such as gentamicin (Garamycin)
  2. potassium chloride (KCl)
  3. folic acid
  4. ferrous sulfate
- 209.** Interactions can occur when two or more drugs are administered to the same patient. An additive effect is achieved with the addition of the second drug. Additive effect is:
1. achieved when each drug acts on receptors having the opposite effect.
  2. equal to sum of the effects of each drug.
  3. apparent when the second drug enhances the response of receptors stimulated by the first agent.
  4. an effect which is greater than the sum of the individual drug effects.
- 210.** Respiratory depression following opiate analgesic administration:
1. occurs rarely and is of little importance.
  2. is the result of decreased respiratory center sensitivity to carbon dioxide.
  3. can be alleviated by giving the patient oxygen.
  4. precludes opiate analgesic administration at night.
- 211.** Within the CNS are receptors that control pain. Stimulation of these receptors by the opiates blocks the sensation of pain. These receptors:
1. are known as nociceptors.
  2. are subdivided into mu, delta, kappa, and sigma receptors.
  3. block the release of prostaglandins.
  4. are up-regulated by the administration of opiate analgesics.
- 212.** The neurocontrol of ventilation rests in several areas of the nervous system. The primary control of inspiration and expiration occurs in the:
1. baroreceptors.
  2. medulla oblongata.
  3. alveoli.
  4. pons.

- 213.** Mr. Green is diagnosed as having respiratory insufficiency due to longstanding restrictive lung disease as a result of working in the coal mines for 35 years. He should be advised to prevent or control respiratory infections by:
1. taking penicillin for the rest of his life as prophylaxis.
  2. smoking low-tar cigarettes.
  3. taking influenza injections and broad-spectrum antibiotics as prescribed.
  4. having periodic blood studies to determine his PO<sub>2</sub>.
- 214.** Expiration is a(n):
1. active process that involves the relaxation of the intercostals muscles and the diaphragm.
  2. passive process that involves the relaxation of the intercostals muscles and the diaphragm.
  3. active process that involves the contraction of the intercostals muscles and the diaphragm.
  4. passive process that involves the contraction of the intercostals muscles and the diaphragm.
- 215.** What effect do beta blockers have on a patient with diabetes mellitus?
1. Beta blockers induce hypoglycemia.
  2. None. Beta blockers are well tolerated by patients with diabetes mellitus.
  3. A significant slowing of the sino-atrial node firing results in a decreased heart rate.
  4. Beta blockers increase peripheral vascular disease in patients with diabetes mellitus.
- 216.** Describe the effect of the administration of testosterone to boys before completion of bone growth.
1. accelerated long bone growth
  2. approximately 50 percent increase in height
  3. inhibition of normal bone growth
  4. delayed puberty
- 217.** What is the primary factor(s) that influence a family's conceptualizations of health and illness and whether they seek healthcare services?
1. health beliefs about Health Care Seeking and Health Action
  2. do not want to change lifestyles
  3. have no education, but lots of money
  4. too many sick children.
- 218.** Which of the following fits within the occupational safety and health categories?
1. motorcycle helmets
  2. firearms safety
  3. swimming lessons
  4. noise exposure
- 219.** Which one of the following assessment findings indicates a lifestyle risk factor?
1. obesity
  2. overcrowded housing
  3. sunbathing
  4. industrial-based occupation
- 220.** A nurse using a holistic approach with a client makes which one of the following statements?
1. "I would like you to perform this exercise once a day."
  2. "Your physician has left orders for you to follow."
  3. "The laboratory tests reveal the need to reduce your daily percentage of fat grams."
  4. "Do you think you would be able to adapt your diet and activity to lower your blood glucose levels?"
- 221.** When teaching a group of elder adults about nutrition which of the following should the nurse include?
1. 12–14 percent of each day's calories should be protein.
  2. Total fat should be limited to less than 15 percent of the daily diet.
  3. Carbohydrates should be 30 percent of the daily food intake.
  4. Concentrated sweets should be no more than 5 percent of the total calories.
- 222.** An elder client is receiving alendronate sodium (Fosamax). A nurse should plan to observe the client for side effects which include?
1. photophobia
  2. heartburn
  3. rash
  4. hypotension

- 223.** When performing a physical assessment on an elder adult, which of the following clinical manifestations should the nurse relate to aging?
1. decreased capacity to inhale, hold, and exhale breath
  2. cough reflex increased
  3. respiratory movement impaired by lordosis
  4. decreased inflation of lungs
- 224.** All of the following nursing strategies are successful when caring for an elder who has experienced tactile losses except?
1. Encourage the use of hot water bottles or heating pads.
  2. Provide assistive devices such as canes or walkers.
  3. Frequent position changes if bedridden or wheel chair bound.
  4. Use firm gentle pressure when touching the elder.
- 225.** While taking the client's history, the nurse develops a genogram. What is the purpose of the genogram?
1. to identify potential or undetected physiological disorders
  2. to identify genetic and familial health problems
  3. to identify the chief complaint
  4. to identify chronic disorders
- 226.** The CQI process does not end with data analysis. Perhaps most important, after evaluating the data gathered in a meaningful way, the next step of the process is:
1. to consider if thresholds are met. If no problem is identified the team may decide to further monitor at some point in the future. If thresholds are not met, the staff must attempt to identify the cause.
  2. to identify problems from all the collected information.
  3. to communicate the results.
  4. to choose another aspect of care to monitor.
- 227.** Which of the following responses most fully answers a mother's question, "Why should I immunize my child against measles?"
1. to prevent infections that could re-emerge
  2. to prevent outbreaks in schools and communities
  3. to protect your child from a disease common in other parts of the world and one that could occur in the United States
  4. a lot of people stopped immunizing in the '80s and '90s and more than 100 kids died.
- 228.** A patient is recovering from an amputation, secondary to a motorcycle accident. This dramatic change will most likely trigger problems in:
1. body image change.
  2. role performance.
  3. self-concept.
  4. personal Identity.
- 229.** A patient following a radical mastectomy will initially have problems with:
1. self-esteem.
  2. self-concept.
  3. body image.
  4. role performance.
- 230.** The altered image change seen in an individual with anorexia nervosa is caused by:
1. desire to be thin.
  2. fear of being fat.
  3. a need to be like peers.
  4. genetic trait.
- 231.** The primary causes of obstruction in long-standing Crohn's disease in which there have been repeated exacerbations of inflammation are:
1. volvulus and intussusception.
  2. slowed peristalsis and strictures.
  3. adhesions and narrowing of the lumen.
  4. ulcerations and incarcerated bowel segments.

**232.** The nurse suspects that a patient with diabetes is experiencing ketoacidosis. What manifestations is the nurse observing?

1. tachycardia and pale, moist skin
2. hypertension and dry mucous membranes
3. hypotension and dry, hot, flushed skin
4. bradycardia and dry, pale mucous membranes

**233.** A client, who is 64 years old, has chronic renal failure. The nurse observes the following measurements: BUN 64, hemoglobin 8.8, creatinine 2.4, and a urine output of 250 ml over the past 24 hours compared with a 10000-ml intake. An appropriate nursing diagnosis for this set of data is:

1. high risk for injury related to possible seizure activity.
2. fluid volume excess related to inability of the kidney to maintain body fluid balance.
3. anemia related to impaired renal function.
4. urinary retention related to intake greater than output.

**234.** A male client is receiving gentamicin sulfate intravenously for a post-surgical wound infection. Which outcome is included on his care plan for the nursing diagnosis, “high risk for injury related to intravenous antibiotic therapy”?

1. Wound remains clean and moist with healthy granulation.
2. Client reports freedom from pain
3. Lung sounds remain clear.
4. BUN remains between 10 and 20 mg/dl.

**235.** Nursing advocacy is:

1. making decisions for patients.
2. encouraging patients to follow all doctor’s orders.
3. encouraging and supporting patient decisions concerning rights and healthcare choices.
4. completion of all forms for patients.

**236.** A nurse is drawing blood on a male client who is being tested for syphilis. The client says, “I am really worried that I might have syphilis.” What is the appropriate response of the nurse?

1. “Did you wear a condom during intercourse?”
2. “Tell me more about what worries you.”
3. “What makes you think you have syphilis?”
4. “Have you told your sexual partner about it?”

**237.** Which of the following statements by a client who has just tested positive for tuberculosis reveals he is able to care for himself?

1. “After treatment, I will not have a relapse.”
2. “I can stop taking my medication in two weeks.”
3. “I will take my medication when I feel bad.”
4. “I will take my medication as ordered.”

**238.** Nurses realizing a supervisory relationship understand that core functions are all of the following except:

1. supporting supervisees making sure they have needed resources and support.
2. enabling the supervisees to have some influence over their work.
3. ensuring the desired outcome(s).
4. working in an office in the building across the street.

**239.** Efficient time management refers to:

1. getting all tasks done without regard to prioritization.
2. only one technique used in time management.
3. refers to using the appropriate resources to do the right task.
4. refers to the quality of doing the right task correctly.

**240.** The facilitation of the best use of time is:

1. time management.
2. priority-setting.
3. stress management.
4. crisis management.

- 241.** A 14-year-old, first-time mother is going home from the hospital with her newborn. An appropriate referral for support of this mother-infant dyad might be:
1. a home care agency with maternal-infant services.
  2. an adoption agency.
  3. referral to Planned Parenthood.
  4. nurse midwife.
- 242.** You are the emergency room nurse on duty when a young man is admitted from an auto accident with massive head injuries and admitted to the ICU. You know that if he is judged to be brain dead and organ donation is suggested:
1. the family will not be charged for the cost of organ donation.
  2. organ donation will disfigure the donor and will potentially alter the funeral arrangements.
  3. the family will not be asked for organ donation because of the massive head injuries.
  4. his name and personal information will be given to the organ recipient so that there can be communication after the transplant.
- 243.** A group that lobbies at the state and federal levels for advancement of the nurse's role, economic interest, and healthcare is the:
1. American Nurses Association.
  2. state boards of nursing.
  3. National Student Nurses' Association.
  4. American Hospital Association.
- 244.** A nurse who fails to check an armband prior to administering medications is:
1. negligent.
  2. liable.
  3. following the five rights of medication administration.
  4. correctly using principles of time management.
- 245.** To force treatment on a patient without their consent could result in a charge of:
1. battery—offensive touching.
  2. slander.
  3. defamation.
  4. perjury.
- 246.** The general consent form signed upon admission to the hospital gives consent for:
1. any/all treatments.
  2. investigative procedures according to defined protocols.
  3. surgical procedures.
  4. administration of medications.
- 247.** Incidents are always involving:
1. patients.
  2. family members or visitors.
  3. staff.
  4. all of the above.
- 248.** Ethical decision making is a process of steps that includes all of the following except:
1. consider the choices of action.
  2. collect data.
  3. analyze and interpret the data.
  4. decision making based on historic policies and law.
- 249.** Primary functions of Ethics Committees are all of the following except:
1. assist institutions in the development of ethical policies.
  2. ensure that policies are being implemented and understood.
  3. make determinations of guilt if the right decision is not made.
  4. serve as a resource for specific client situations with ethical aspects.
- 250.** Mrs. T. is an 80-year-old client admitted to your nursing unit with a diagnosis of weakness, status post fall. The admission face sheet indicates that she is widowed, and lives alone. As you work through your nursing admission assessment, which of the following would be the least priority concern?
1. Ask Mrs. T. about the details of her fall.
  2. Does Mrs. like to read?
  3. Ask Mrs. T about her ability to shop and cook for herself.
  4. What medications has she been taking?

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**251.** A nurse's appropriate priority setting is initially contingent upon which step of the nursing process?

1. assessment
2. planning
3. intervention
4. evaluation

**252.** Your ER patient is a 10 year old with contusions that may have been inflicted by a caregiver. As a nurse advocate to facilitate the patient's care, you would do all of the following except:

1. identify and document the patient's condition.
2. tell the mother.
3. follow your facility protocol for mandatory reporting of suspicion of child abuse.
4. discuss your findings with the physician in charge.

**253.** An 85-year-old man with end-stage prostate cancer has a living will expressing his desire for a dignified death and comfort care measures without resuscitation measures. advocate, your role is to:

1. support the daughter's decision.
2. encourage the patient to revoke his living will.
3. support the patient's decision and encourage him to discuss his feeling with his daughter.
4. ignore the patient's decision for non-resuscitation.

**254.** Mr. Davis, an 80 year old, is being discharged from the hospital with a new diagnosis of lung cancer. The adult children have made arrangements for him to live with his youngest son. To promote optimal continuity of care, the nurse should:

1. immediately arrange for hospice care.
2. convince the family that institutionalized care would be better.
3. assist with the discharge as planned.
4. explore options for community health services with the family.

**255.** In planning for a patient's discharge from the hospital, the nurse needs information on all of the following except:

1. type of insurance.
2. availability of caregivers for the patient.
3. transportation available.
4. banking services used.

**256.** If the physician orders 250 milliliters of packed red blood cells (RBC) for a patient, you can assume that this therapy is for treatment of:

1. thrombocytopenia.
2. anemia.
3. leukopenia.
4. hypoalbuminemia.

**257.** Mr. Thompkins requires a whole blood transfusion. In order for Transfusion Services (the blood bank) to prepare the correct product, a sample of the patient's blood must be obtained for:

1. a complete blood count and differential.
2. a blood type and cross-match.
3. a blood culture and sensitivity.
4. a blood type and antibody screen.

**258.** The American Hospital Association's "Patient's Bill of Rights" is applicable in:

1. a hospital.
2. a nursing home.
3. a free-standing urgent care facility.
4. home care.

**259.** A client's rights to care have been a cornerstone in ethical dilemmas due to the cost and affordability of healthcare. Determination of how to meet patient's needs have presented challenges to nurses in all of the following ways except:

1. providing considerate and respectful care.
2. providing care when the patient refuses based on cost.
3. preserving continuity of care when providers availability is limited due to cost.
4. availability of community resources.

**260.** A new manager does not seem to trust that assignments will be completed as delegated without much supervision and direction. This style of management is called:

1. laissez-faire.
2. autocratic.
3. democratic.
4. diplomatic.

**261.** You have access to patient laboratory reports on your work computer and have accessed one patient's current test results. You should:

1. not leave the results visible on the screen when you step away from the computer.
2. not leave the results visible on the screen where a visitor to your unit may see them.
3. always sign off of the computer when it is not directly in use so that unauthorized persons may not access confidential information.
4. all of the above.

**262.** Maintaining the confidentiality of patient information is:

1. a moral obligation.
2. an ethical obligation.
3. expected only in an acute care institution.
4. both a legal and ethical obligation.

**263.** You are working in the emergency room when a patient is admitted with right-sided weakness and swallowing difficulty. The physician specialist who may be expected to evaluate this patient would be:

1. a neurologist.
2. a gastroenterologist.
3. a physiatrist.
4. pulmonologist.

**264.** Which of the following statements is incorrect about why DTaP is felt the superior form of immunization today?

1. It can be combined with more vaccinations reducing the need of multiple injections.
2. DTaP has a safer side effect profile than the DTP.
3. Studies indicate that it confers equal pertussis immunization as the DTP when administered correctly.
4. There are many available forms on the market, and they can all be used interchangeably for all five initial doses.

**265.** What is the correct term for the situation characterized by a person or group of persons experiencing a stressful event(s) that result in failure of usual coping mechanisms and/or the utilization of problem-solving resources?

1. crisis
2. stressor
3. depression
4. hypomania

## Answers and Explanations for Practice Test 2

For your reference, the appropriate review chapter is listed at the end of each answer explanation below.

1. (3) After the first trimester the pregnant woman should avoid exercising in the supine position. This is associated with decreased cardiac output. As a general rule, pregnant women should not engage in exercise that causes their heart rate to exceed a maximum of 140 beats per minute. Per the American College of Obstetricians and Gynecologists, pregnant women should not exercise to the point of fatigue or exhaustion. Hyperthermia may have teratogenic effects on the fetus so pregnant women should avoid hot tubs and saunas. *Health Promotion and Maintenance*
2. (2) Because of the pressure placed on the vena cava by an enlarging uterus, a pillow should be placed under the right hip of the woman if she is lying on her back during intercourse. This will displace the uterus off the vena cava. In times past couples were counseled to avoid sexual intercourse during the last 6-8 weeks of their pregnancy. We now know that if there are no complications such as a multiple pregnancy, threatened abortion or an incompetent cervix, etc., there is no reason to limit sexual activity during the last weeks. Orgasms are typically much more intense during the last weeks of pregnancy and may even be followed by cramping. During the first and third trimesters many women experience a decreased sexual desire. During the second trimester the sexual desire may increase. *Health Promotion and Maintenance*
3. (4) In addition to nursing diagnoses applicable to all pregnant women, the pregnant couple over the age of 35 may have additional concerns about the well-being of their baby as it relates to Down syndrome or other genetic disorders. Most couples over the age of 35 are more financially secure and have fewer concerns related to the cost of a birth. Couples over the age of 35 may have experienced infertility problems, births many years before, or have had problem births. They would not have had the opportunity to build confidence or if previous births were long ago this pregnancy would feel like the first. Unless there is a pre-existing health problem the woman should not be at increased risk of physical injury related to her age. *Health Promotion and Maintenance*
4. (1) The combination of results presented in this situation may be the result of a fetus with Down syndrome. A neural tube defect can be detected with MSAFP but once the defect has occurred an increase in folic acid will not change it. Taking folic acid before becoming pregnant and continuing through the pregnancy can be beneficial to prevent neural tube defects. The physician needs to be notified of the results and the nurse could anticipate referral for an amniocentesis. The parents will have to be consulted to be sure this is a test they want done. If the initial glucose screen comes back positive the nurse can per protocol order a glucose tolerance test. But, the laboratory tests in the question would have no impact on ordering a plasma glucose level. *Health Promotion and Maintenance*
5. (2) The Denver II is a screening test, not diagnostic. The results indicate what tasks the child was able to perform the day of the test only. It is not an intelligence test so no IQ score is obtained, it does not measure development. The word measure implies a diagnostic result. The test does not determine whether a child's development is not normal. It screens only. If a child has a result other than normal that child either needs to be rescreened or evaluated by a developmental specialist to determine if the development is normal or not. *Health Promotion and Maintenance*
6. (2) Most children walk between 11 and 15 months of age. To tell the parents that children walk by 12 months of age causes them concern needlessly because their child would actually have until 15 months of age before the nurse would be concerned. All children 18 and 24 months of age should be walking for some time. *Health Promotion and Maintenance*
7. (3) Industry versus inferiority is the developmental stage of school age children. Trust versus mistrust is the developmental stage of infancy. Initiative versus guilt is the developmental stage of preschoolers, and autonomy versus shame and doubt is the developmental stage of toddlers. *Health Promotion and Maintenance*
8. (2) Research has shown that sleeping with adults can contribute to sudden infant death syndrome. The mechanism is believed to be the rebreathing of carbon dioxide as the sleeping child snuggles against the parent. Increased attention during the day will not stop a child from wanting to sleep with their parent. In some cultures it is the norm for children to sleep with their parents. Some occasions provide reasons a parent might want the child to sleep with them, such as illness, nightmares, or bedroom space. Unless parents want this to become a habit, they will have to take measures to be sure it is only for the duration of the circumstance. While there is no guarantee being accused of abuse won't happen that is not the usual concern about a young child sleeping with a parent.



There is not an automatic connection between sleeping with the parent and abuse. Should the parent or child voice concerns about behaviors consistent with sexual abuse further investigation is warranted. *Health Promotion and Maintenance*

9. (4) Beauticians are excellent referral sources for the care and styling of wigs. They are able to show the client how to use combs, clips, and otherwise style and care for the wig. Clients should purchase and begin wearing their wigs before all their hair falls out. This will give them and others a chance to figure out how they want to style it. Also since it is not totally predictable when the hair will fall out, they will be prepared when it happens. The wigs are considered a medical prosthesis and are tax-deductible if the client keeps the receipt and otherwise qualifies for the medical expense deduction. The American Cancer Society gives the client their first wig." *Health Promotion and Maintenance*
10. (4) The client is concerned how others will view them, often anticipating worse reactions than exist. Allowing the significant others to share their feelings and fears provides a forum for them to offer support to the client despite their feelings and fears. The nurse is then in a position to assist the client and significant others in developing new coping patterns. Turbans and scarves should be encouraged when the client doesn't want to wear the wig. Most clients prefer not to be seen bald, and many times the wigs feel too hot. Hair usually does grow back but often is of a different color or texture. Encourage the client to ask for assistance from friends and relatives. The nurse can encourage them to consider how they would want to help if the situation were reversed. *Health Promotion and Maintenance*
11. (2) The nurse should use role playing to assist the client in sharing their feelings about the lost body part or function. The nurse and client can take turns being the client and significant other. The nurse should assess what the loss means to the client, not tell them what it should mean. Clients should be allowed to express their feelings and to grieve. Telling them to "get over it" communicates that their grief isn't valid. They should gradually be encouraged to assume self-care responsibilities. The nurse should expect a client who has experienced the loss of a body part or function to respond with denial, shock, anger, and depression. *Health Promotion and Maintenance*
12. (2) During the first trimester, the first 12 weeks of conception, the woman may experience a tingling sensation in her breasts. This is normal and should not alarm her. The tingling sensation is also present in the third trimester. Striae do develop on the breasts during pregnancy but is most common in multiparas, not primiparas. Colostrum is not present until after the 12th week of gestation. After 20 weeks of gestation a secondary areola appears and is characterized by washed-out spots surrounding the primary areola. *Health Promotion and Maintenance*
13. (1) Ice will minimize swelling, as well as decrease discomfort. *Reduction of Risk Potential*
14. (2) Headache is a common side effect of a lumbar puncture, due to removal of cerebrospinal fluid, not the other options. *Reduction of Risk Potential*
15. (4) The client must usually lie supine, but may be allowed to have the head of the bed slightly elevated, not the other options. *Reduction of Risk Potential*
16. (4) These values are indicative of metabolic alkalosis. The other values indicate other acid-base imbalances *Reduction of Risk Potential*
17. (2) These values are indicative of metabolic acidosis. The other values indicate other acid-base imbalances *Reduction of Risk Potential*
18. (3) These values are indicative of respiratory alkalosis. The other values indicate other acid-base imbalances *Reduction of Risk Potential*
19. (1) Weight gain is a sign of hypothyroidism. The remaining options are signs or symptoms of hyperthyroidism. *Physiological Adaptation*
20. (3) The ovary functions to release oocytes, not the remaining options. *Physiological Adaptation*
21. (2) The testes function to produce sperm, not the other options. *Physiological Adaptation*
22. (1) A four-point gait provides for weight bearing on all points that touch the floor and maximum support during ambulation. The three-point gait is used when one extremity cannot bear weight; there is no tri-point gait. A swing-through gait does not stimulate ambulation; it is used when an individual can bear weight but lacks the muscular control needed for ambulation without an assistive device. *Basic Care and Comfort*

23. (3) The purpose of any rehabilitation is to have the client attain a greater sense of self-reliance and independence. Providing rehabilitation in the shortest period of time, in a calm, safe atmosphere and including family members in the client's care to obtain the greatest benefit are other purposes of Mobility Assisted Devices. *Basic Care and Comfort*
24. (2) Nursing involvement in the teaching/learning plan of the client should include all aspects about purchase and use of the walker the client and family should be included in the selection of a walker, but within correct measurements and safety factors for the client. *Basic Care and Comfort*
25. (4) Dyspnea and wheezing is an indication of respiratory component of anaphylactic shock due to dye/isotope used in IVP. Choice 3 is the body's physiologic response to the dye/isotope being injected. Choice 1 is thirst due VPO status and worn out may be due to weakness that follows IVP dye injection. *Basic Care and Comfort*
26. (1) Perineal hygiene requires cleaning from front to back to prevent transfer of e-coli toward the urinary meatus. 2000 cc of fluid will flush bladder to reduce number of bacteria present. Acidic juices created a hostile environment for the organisms. Gantrisin can change color of urine. *Basic Care and Comfort*
27. (4) Nocturia is voiding at night. It may signify kidney problems or it can occur when a person consumes fluids up to going to be or takes a diuretic fluid pill after 3 PM daily. *Basic Care and Comfort*
28. (1) Regular exercising is essential to maintain normal mobility/function. *Basic Care and Comfort*
29. (4) Ages 40–60, an adult's muscle tone and bone density/mass decrease. *Basic Care and Comfort*
30. (4) Recognition of gait patterns may clue the nurse in a certain disease process. Festinating gait is when the patient appears to be walking on his toes and being propelled (pushed forward). Also known as "cogwheel gait." Ataxic gait is characterized by staggering and unsteadiness as in CVA. Spastic gait—walking appears to be stiff and person upon his toes; tends to catch and drag as in Cerebral Palsy. Waddling gait is when feet are wide apart as in waddling duck gait. This gait is used to lower speed in the classic Parkinson's festinating gait. *Basic Care and Comfort*
31. (1) Bathing can be a form of comfort and relaxation; also could make her feel better. *Basic Care and Comfort*
32. (2) In giving perineal care, the nurse needs only gloves (not sterile) and should wash from the pubis toward anus (front to back) so that e-coli and other bacteria are not brought to vaginal area. *Basic Care and Comfort*
33. (4) Taking vital signs on the two clients would be the priority nursing action to determine whether there are emergent problems. Even if one of the clients had TB, the nurse could don gloves and a HEPA filter mask to complete the assignment. Next, the nurse would give the meds that need to be given within a certain time frame. Because changing the dressing might also involve a pain assessment, this would take more time and should probably be done last. *Basic Care and Comfort*
34. (3) After the spermicide is inserted the woman should maintain a supine position to prevent the leakage of the spermicide. Suppositories are not effective until they have dissolved, which may take as long as 30 minutes. Spermicides are widely available over the counter without a prescription. *Health Promotion and Maintenance*
35. (4) For optimal protection the penis should be withdrawn from the vagina while still erect, holding the condom rim to prevent spillage. Vaseline jelly will deteriorate the latex allowing sperm penetration. A water-soluble lubricant such as K-Y jelly should be used. The condom should be applied to an erect penis with a small space left at the end of the condom to allow for ejaculation. *Health Promotion and Maintenance*
36. (3) The female condom can be inserted up to 8 hours prior to intercourse. The female condom is not designed to be used with a male condom. Female condoms are designed for one-time use. The inner sheath is lubricated but does not contain a spermicide. *Health Promotion and Maintenance*
37. (2) Women who have a history of toxic shock syndrome should not use diaphragms or any other barrier method because they are left in place for prolonged periods of time. The diaphragm is a good contraceptive choice for women over the age of 35 who smoke because they should not take oral contraceptives. The diaphragm is also a good contraceptive choice for lactating women who cannot take medications such as oral contraceptives that will inhibit or interfere with lactation. When a woman cannot take or is not interested in taking oral contraceptives the diaphragm is a good alternative. Compliance is an issue with any contraceptive method but a diaphragm does not require a daily compliance. *Health Promotion and Maintenance*

- 38. (2)** Caucasian women over 40 years of age are most likely to be at risk of developing gallbladder disease. *Physiological Adaptation*
- 39. (4)** High fat foods, such as bacon, are most likely to exacerbate acute cholecystitis, due to lack of bile in the small intestine to digest fat. The other options are not fatty foods. *Physiological Adaptation*
- 40. (2)** The physician should be notified of this request, particularly since it may have cultural significance to the Hispanic client. Milk thistle has been shown to protect and promote regeneration of liver cells. The other options are culturally insensitive. Herbal remedies do not require a prescription, but the nurse and physician need to be aware of interactions and side effects the herbs may have. *Physiological Adaptation*
- 41. (2)** Visual disturbances including blurring, halo effect, double vision, and yellow vision can occur with digoxin toxicity. In addition, the patient will vomit initially due to the effect of digoxin on the GI tract and later to stimulation of the vomiting center of the brain, which occurs after the heart muscle has been saturated with digoxin. Digoxin toxicity does not induce these other symptoms. *Pharmacological Therapies*
- 42. (1)** Both loop diuretics and aminoglycoside antibiotics can lead to ototoxicity. When given concomitantly ototoxicity is enhanced. The nurse should observe the patient for subtle changes in hearing. The antibiotics in options 2, 3, and 4 are not known as ototoxic. *Pharmacological Therapies*
- 43. (2)** In addition to the excretion of sodium, chloride, and water, bumetanide administration results in the urinary excretion of calcium and phosphate (proximal tubule effect). Calcium and phosphate are major components of renal stones. The possibility of nephrocalcinosis increases with prolonged use of bumetanide. Bumetanide does not induce acute pancreatitis. Bumetanide may induce hyperlipidemia and aggravate diabetes, resulting in hyperglycemia and glycosuria. Muscle cramping may occur secondary to the hypokalemic effect of bumetanide. *Pharmacological Therapies*
- 44. (3)** Cyclooxygenase (COX) is an enzyme that catalyzes the first step in the synthesis of prostaglandins from arachidonic acid. If COX is blocked prostaglandin cannot be produced. Prostaglandin has a cytoprotective effect on the GI tract. Blockage of this protection can result in GI bleeding and peptic ulcer disease. NSAIDs may slow the progression of Alzheimer's disease. NSAIDs do not directly affect the respiratory or cardiovascular systems. *Pharmacological Therapies*
- 45. (1)** Criteria is that non-pharmacological methods are appealing; expresses anxiety and fear; may benefit from avoiding or reducing drug therapy; want to cope to prolonged pain; and don't get relief from pharmacological agents. *Basic Care and Comfort*
- 46. (1)** Neuropathic pain is the result of a disturbance of the peripheral or central nervous system that results in pain not necessarily associated with an ongoing tissue damage process. It is usually described as shooting or stabbing and is severe in nature. *Basic Care and Comfort*
- 47. (1)** The client is most likely experiencing anxiety because of fears related to the postoperative pain. The best intervention is to reassure him, listen to him, teach him relaxation techniques. *Basic Care and Comfort*
- 48. (3)** The Dietary Supplement and Health, Education Act states, "Herbs, vitamins, and minerals may be sold as long as no therapeutic claims are made on the label." *Basic Care and Comfort*
- 49. (1)** The fruits and vegetables with the highest potassium are: potatoes, apricots, broccoli. Other fruits, vegetables, milk, and grain products have some potassium but are not as high as the three. *Basic Care and Comfort*
- 50. (4)** The weight and height are quantitative values and thus objective data; the other items in options 1, 2, and 3 are subjective data obtained from communication with the client. *Basic Care and Comfort*
- 51. (4)** Verbalizing concerns elicits information about the disease, giving the patient a sense of control and helps the patient face the unknown. *Basic Care and Comfort*
- 52. (3)** Support of the incisional site with external pressure will decrease distention of the incisional site/muscles when coughing. *Basic Care and Comfort*
- 53. (3)** One of the earliest side-effects of chemotherapy is stomatitis. *Basic Care and Comfort*

- 54. (3)** This falls under the mnemonic of ABCD, asymmetric, border irregular, color, diameter (>6mm or a pencil eraser). Option 1 is a normal mole, i.e. doesn't meet above criteria. Options 2 and 4 are large dark greasy warts, usually found on the trunk—2 is premalignant, 4 is benign. *Physiological Adaptation*
- 55. (1)** This patient must be monitored carefully for airway obstruction and respiratory failure. Options 2 and 3 do not provide enough information; option 4 is not likely to be needed on facial burns, much more likely on the trunk or extremities. *Physiological Adaptation*
- 56. (4)** Airway is always first. Burn patients require large amounts of fluid resuscitation in the first 24 hours. When the skin is severely damaged, enormous amounts of fluid are lost causing profound dehydration and inadequate perfusion of organs if the fluids are not aggressively replaced. This may cause pulmonary edema. Patients have trouble maintaining body temperature without skin. The room is kept above 80° F and warming lamps and warm fluids (IV and for wound care) are used. Patients who've been burned have varying levels of pain. Full thickness burns may not have much pain early on as the nerves may be burned away with the skin. Pain is important, but physiologic needs must come first. *Physiological Adaptation*
- 57. (1)** Amylase rises within a few hours and falls within a few days of acute pancreatitis. Lipase lags behind, persisting for about 7 days. Bilirubin may be elevated if the pancreatitis is caused by obstructing gallstones, but this is not specific and only a small number of persons with gallstones will develop pancreatitis; glucose is often elevated during the acute inflammatory phase but this is neither specific nor diagnostic. *Physiological Adaptation*
- 58. (2)** A pattern of behavior known as the cycle of abuse has been described in the literature. It involves a honeymoon stage followed by build-up of stress, an angry outburst that may involve beating, followed by reconciliation and honeymooning phase. Patients who do not receive help are at increased risk including homicide. *Psychosocial Integrity*
- 59. (2)** The definition of rape is sexual intercourse against someone's will. It is a degrading, brutal crime of violence and can occur between any two persons regardless of their marital status. *Psychosocial Integrity*
- 60. (1)** The risk for suicide is greatest when a client with depression begins to have more energy. Antidepressants will need to be taken for 4–6 weeks for maximum therapeutic benefit. A person who has had a previous episode of depression is more likely to have another episode later in life. *Psychosocial Integrity*
- 61. (3)** Light therapy for 45 minutes per day has been effective in many clients with seasonal affective disorder. If the light therapy is not effective, an antidepressant may be added. *Psychosocial Integrity*
- 62. (3)** Results from offices of justice and victims of crime have documented the effectiveness of sexual assault nurse examiner programs (SANE) and the improvement of community response they engender. Providing social support such as adequate police officers and post trauma counseling are also helpful. There is no documented benefit of specialized gynecology care over the SANE program. In fact, RN nurse examiners typically outperform medical doctors, including OB-GYN, in situations such as the treatment of rape. *Psychosocial Integrity*
- 63. (2)** Nurses are mandated to report suspicions and incidences of abuse. Ensuring the child's safety is a priority issue. It is important to let the child know at the outset that the nurse may be required to inform authorities. Failure to inform the child can result in loss of trust. *Psychosocial Integrity*
- 64. (3)** Children ages 3–5 are in the phallic stage of Freud's theory. During this stage their focus is on the genitals. Male children in the phallic stage experience the Oedipus complex in which they fear their father will cut off their penis for being attracted to their mother. Female children in the phallic stage experience the Electra complex characterized by a belief that she at one time had a penis but it was cut off and blames her mother for this. Repressed sexual impulses are characteristic of the Latency stage, which occurs after the phallic stage. The first stage of sexual development, according to Freud, is the oral stage. Children experience the oral stage from birth to 12–18 months of age. During the oral stage pleasure is derived from oral stimulation such as sucking. The anal stage is from 1–3 years of age and is characterized by a focus on elimination functions and gaining control over body sphincters. *Health Promotion and Maintenance*
- 65. (1)** To some extent all of the options are contained in behavioral theories of sexual development. Behaviorists believe that sexual behavior is measurable and that it is both physiological and psychological responses to learned stimuli and a reinforcement event. However, they also consider the sexual behavior of adults who care for children as very important. They believe that sexual abuse in childhood leads to sexual difficulties in adults.

Women who were sexually abused as children may experience depression, self-destructive behavior, suicidal attempts, anxiety, and panic attacks. Men who were abused as children can experience erectile dysfunction, premature ejaculation, and low sexual desire. *Health Promotion and Maintenance*

- 66. (1)** Sexual dysfunction is a common side effect of SSRIs. While the medications have the capability of causing problems in any phase of the sexual response cycle, one side effect common to both sexes is anorgasmia, or the inability to have an orgasm. Clients on SSRIs are more likely to have decreased libido, delayed ejaculation and erectile dysfunction. Priapism is the term used to describe a prolonged erection lasting 4 hours or more. This is an unlikely occurrence while taking SSRIs. *Health Promotion and Maintenance*
- 67. (1)** Heterosexual sexual contact is the leading mode of transmission for women. The difference between options 1 and 4 is protection. Five life time partners are not considered to be a high risk for transmission, particularly if the sexual contact was protected. Intravenous drug use causes fewer women to be infected with HIV/AIDS than does heterosexual contact. Even if intravenous drug use was the leading mode of transmission it is not a sexual practice, which is what the question was about. Lesbian sexual contact has a low risk of HIV/AIDS infection as there is limited exchange of body fluids. *Health Promotion and Maintenance*
- 68. (2)** After menopause there are two main vaginal changes: decreased lubrication and decreased blood flow to the vagina. Decreased estrogen levels contribute to the decreased lubrication. Additionally there is decreased elasticity of the vaginal walls and decreased sensation in the breasts. *Health Promotion and Maintenance*
- 69. (3)** Healthy, functioning families maintain emotional contact across the generations and between family members while maintaining the necessary lines of authority. Children in functioning families are responsible for age-appropriate activities and have age-appropriate privileges. Functioning families encourage differences between family members so that each member can enjoy personal growth and creativity. In functioning families differences are resolved between the two members who are having the problem without having to involve an outside third party. *Psychosocial Integrity*
- 70. (2)** All of the options, except option 2, are characteristics of families that have a level of pathology within them. Functioning families actually value a positive emotional climate more than valuing what “should” be done or doing what is “right.” Option 1 describes a “super spouse” which can be either a “super wife” or “super husband” and denotes that the other spouse is actually under functioning, passive, dependent, and compliant. In option 3 it is the blurring of lines of authority that make the closeness of the three generations pathologic. In this situation the children end up acting out because there isn’t a definitive parental figure or clear limits set. Children who have to parent their younger siblings many times are too tired to perform well in school and have poor peer relationships because they have nothing in common with their peers, as suggested in option 4. *Psychosocial Integrity*
- 71. (3)** Establishing the current household configurations and relationships between members is an important purpose of the genogram and is always included. All first and second degree relatives are included, dead or alive. If the relative is dead a designation is made to show that. The health status of each person is listed, including the client, ill family members, well family members and what a deceased family member died of. Three generations of family members are included in the genogram. *Psychosocial Integrity*
- 72. (4)** Emotional cutoff is the concept in family systems therapy that describes the dysfunctional how families respond to intense crisis through emotional isolation or geographic distance. Differentiation is a concept that describes the separation between thinking and feeling so that an individual in the family is not dominated by the family’s emotional system. Family projection processes occur when spouses project their problems onto one or more of their children to avoid emotional conflict with the other spouse. Triangulation or family triangles can be described as predictable emotional processes that involve a third party. *Psychosocial Integrity*
- 73. (2)** The client who has recently had surgery for repair of the mandible will have immobilization of the jaws, usually by wiring the jaws. This wiring may remain on for 4–6 weeks. Therefore, certain dietary changes need to be made, so that the client does not become malnourished. The remaining diagnoses do not necessarily relate to a client who has just had mandibular surgery. *Reduction of Risk Potential*
- 74. (4)** Eighty percent of clients experience phantom limb sensation after an amputation, which includes such sensations of pain, cramping, and coldness. This is important for the nurse to know, so that she provide effective interventions, and not disregard the client’s complaints. *Reduction of Risk Potential*

- 75. (3)** The residual limb sock should be changed daily, in order to maintain cleanliness, and prevent infection to the stump. The other statements indicate correct understanding of stump care. *Reduction of Risk Potential*
- 76. (1)** In the transaction model, stress is very personal experience and varies widely among individuals. Choice 2 represents the stimulus model and Choice 3 the response model of stress. External resources and support are a factor in determining stress levels, but omit the key aspects of internal/personal influences. *Psychosocial Integrity*
- 77. (3)** With stress, respirations increase, pupils dilate, peripheral blood vessels constrict, and the heart rate increases. *Psychosocial Integrity*
- 78. (3)** The interrelated facets of Mental Health include concentration, social systems, hobbies, family activities, relaxation, exorcism, nerve teas, and avoiding certain people who can cause disease. *Psychosocial Integrity*
- 79. (2)** Mental and affective disorders such as depression or chronic stress may affect a person's desire to move. Chronic fatigue or fatigue can also be a basis. *Psychosocial Integrity*
- 80. (3)** Denial is the chief psychological defense employed by substance users and addicts. *Psychosocial Integrity*
- 81. (3)** Addiction and physical dependence are not synonymous. When a patient develops opioid tolerance, a higher dose will be necessary. All drug selection for pain management should be guided by the WHO model. *Psychosocial Integrity*
- 82. (1)** The client has the right to refuse a transfusion. Many Jehovah's Witnesses believe that receiving any blood product is not acceptable. Agencies have a transfusion refusal form the client can sign in order to provide documentation and legal protection. The remaining options are not culturally sensitive. It is not legal to give a transfusion if the client refuses it. *Reduction of Risk Potential*
- 83. (3)** Packed red blood cells may be administered over a maximum of 4 hours. If they are administered over a longer time than this, there is a risk of infection from the cells being at room temperature for a lengthy period. *Reduction of Risk Potential*
- 84. (2)** This is the only option that will prevent air embolism in clients with central lines. The head-down position should be used during insertion, a pump with an in-line air detector should be used for IV fluid administration, and an air-occlusive dressing should be used after removal. *Reduction of Risk Potential*
- 85. (4)** Simultaneous attention to both disorders by appropriately skilled and experienced treatment professionals is the most effective approach in addressing co-occurring disorders. Serial programs have difficulties because neither program wants to treat the client first. Attending two separate programs causes problems because of incompatible treatment plans and inadequate communication *Psychosocial Integrity*
- 86. (2)** Initially, the nurse focuses upon building trust by using empathy, calmness and gentle eye contact. The client is provided clear, direct, simple directions. When the client is comfortable, the nurse can explore the delusion and the emotional undertones. *Psychosocial Integrity*
- 87. (3)** Society assumes that men have the ability to defend themselves and are able to handle any unwanted attack. The male sexual abuse victim may perceive that helping professionals often do not believe the assault occurred, be fearful of questions about his sexuality, or may be unable to explain why he did not ward off the attack. The nurse needs to approach the situation in a calm supportive manner. *Psychosocial Integrity*
- 88. (4)** Based upon Maslow's hierarchy, physical injuries are always treated first. The other actions may be taken, but are secondary to meeting physiological needs. *Psychosocial Integrity*
- 89. (3)** Tertiary prevention is the ability of the client to maintain wellness through adaptation. This client was able to change his diet to eliminate the GI symptoms associated with celiac sprue disease and maintain his wellness through this adaptation. Primary prevention involves activities that are utilized to promote or prevent illness or injury. Secondary prevention involves early detection of a disease or illness, and quick intervention to aid the client in maintenance of the disease or injury. Health promotion is any activity that increases a client's health and wellness. *Health Promotion and Maintenance*
- 90. (2)** The radial artery is the vessel that is used to obtain an arterial blood gas, because it is most easily accessible, and safest to draw from. The cerebral artery is located deeply in the head. The carotid artery in the neck is not safe to draw from. The ulnar artery is smaller than the radial artery, and more difficult to locate. *Reduction of Risk Potential*



- 91. (3)** Condoms or a barrier method are the only mechanism for the prevention of sexually transmitted disease. If the patient misses a pill, she is at an increased risk for getting pregnant. STD's can be contracted by any type of sexually encounters, including oral and anal sex, and are only prevented with the use of condoms or a barrier method. Birth control pills are not effective against the prevention of STD's. *Health Promotion and Maintenance*
- 92. (4)** Increasing her calcium intake can replace the calcium she may be losing and increase bone density. Exercise can help in reducing bone loss. Since the client has not been diagnosed with osteoporosis, exercise should not contribute to bone fractures. A sedentary lifestyle and a decrease in activity can increase her risk for bone loss. Sodium intake has no direct effect on bone loss. *Health Promotion and Maintenance*
- 93. (4)** Developmental considerations of the pediatric client is of great importance because rapid physiological and psychological changes in children affect growth and development. The developmental health history assessment of a child is usually more detailed than an adult's. Skilled assessments by the nurse, using appropriate Pediatric tools can further the child's health status and recovery. *Health Promotion and Maintenance*
- 94. (4)** The nurse should assess role and relationship patterns thoroughly for an elderly client because losses associated with aging and changed social roles may affect the client's health status. This area has a strong effect on self-esteem, cultural and spiritual needs, and social support patterns. *Health Promotion and Maintenance*
- 95. (1)** On otoscopic assessment, the tympanic membranes normally appear pearly gray. *Health Promotion and Maintenance*
- 96. (2)** The client should not apply preparations to the breast, nipple or underarm on examination day. The procedure uses low-dose x-ray technology and takes about 15 minutes. There is some discomfort due to compression of the breast. *Health Promotion and Maintenance*
- 97. (4)** is correct. Choice 1 is incorrect. CPR is a component of DNR, but depending on state's definitions and protocols, DNR may include other aspects of care. Choice 2 is incorrect. DNR status applies to care across the entire continuum. Choice 3 is incorrect. Use of artificial nutrition/hydration is a subpoint of the DNR discussion, but other aspects of care are included as well. *Coordinated Care*
- 98. (2)** Advocacy involves helping not only those who cannot make decisions for themselves, but emphasizes support in decision-making so that patients have the information necessary to make informed decisions regarding treatments, costs, care needs, and risks of treatment. *Coordinated Care*
- 99. (4)** Meals on Wheels is the community provider of nutritional meal assistance. The local VNA provides skilled therapeutic services, hospice provides individuals with terminal illnesses with therapeutic care and assistance at the end-of-life, and AARP is an organization of older adults which provides education, insurance, information services and political action for seniors. *Coordinated Care*
- 100. (3)** Prevention is the key to lowering the incidence of lead poisoning in children. Removing lead from the environment is the only sure way to prevent the effects of toxic exposure. *Safety and Infection Control*
- 101. (4)** The ability to be mobile (crawling, walking, climbing) combined with inquisitiveness, immaturity, and inability to execute reasonable judgment result in increased risk of accidents even for the hospitalized pediatric client. *Safety and Infection Control*
- 102. (4)** Assessing the client's knowledge and then honestly answering the client's question is the best course. Obviously, the mother is concerned that her fetus has been harmed via her own occupational exposure to pesticides, an ever-growing risk to some workers. Emotional support should be given as the client receives her prenatal care. Clinical evidence is mounting regarding links to neurological injury and pesticides including neural tube defects. *Safety and Infection Control*
- 103. (4)** Treatment of tuberculosis is multi-drug therapy typically isoniazid, rifampin, pyrazinamide and ethambutol. Treatment is long term usually over a period of six months if the client is not drug resistant, but up to 24 months if there is drug resistance. *Safety and Infection Control*
- 104. (3)** The "Patient's Bill of Rights" describes rights to privacy and confidentiality, the right to refuse to participate in research, the right to continuity of care, and the right to refuse treatment. *Coordinated Care*

- 105. (1)** Political power results from one's ability to work within systems, agencies or through policy in order to effect change. Personal power is based upon one's charisma and self confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based upon one's professional skills and abilities resulting from one's recognized expertise in an area of practice. *Coordinated Care*
- 106. (3)** Many times in medical teaching-learning situations, the identity of the patient is known through the presentation information. When a patient's identity is known, the teaching-learning process may still occur while maintaining the confidentiality of the information presented and the learner need not remove him/herself from this process. It is important, however, to remember not to continue the spread of the information through discussions where information may be dispersed publicly. It is also important to appropriately shred written documents which may carry information that may be identified as belonging to a specific patient. *Coordinated Care*
- 107. (2)** The wound care nurse will be important in this patient's recovery in assisting with regimens specific to healing venous ulcers in a diabetic. A physical therapist may later be called upon to assist with mobility concerns, along with a DME specialist if walkers or assistive devices are needed. A neurologist would be needed only if neurological disease were suspected. *Coordinated Care*
- 108. (1)** Primary prevention is the healthcare practices and lifestyle behaviors that help healthy people stay healthy. The goal of secondary prevention is to help those with chronic illness manage their disease and avoid complications. Tertiary healthcare is helping clients adapt to losses or complications that result from a disease or chronic illness. Primary preventative care is not covered by all insurance plans. *Coordinated Care*
- 109. (3)** Vancomycin is a serious antibiotic only used in a few situations such as methicillin resistant infections and clostridium difficile infection. It is a beta lactam antibiotic that inhibits cell wall synthesis in the susceptible bacteria. It is the drug of choice for methicillin-resistant pathogens and is given only by the intravenous route. *Safety and Infection Control*
- 110. (1)** The CDC now recommends alcohol based hand gels for routine hand hygiene for healthcare workers including nurses. Betadine and benzalkonium chloride (BAC) are too harmful for routine use, and soap and water is inconvenient and promotes nonadherence. *Safety and Infection Control*
- 111. (4)** The Classifications of Restraints are Physical and Chemical. Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to the client's body; they cannot be removed easily and they restrict the client's movement. Chemical restraints are medications such as neuroleptics, anxiolytics, sedatives, psychotropic agents used to control socially disruptive behavior. The purpose of restraints is to prevent the client from injuring self or others. *Safety and Infection Control*
- 112. (3)** "Environmental restraints" are barriers (pieces of furniture or large plants) to keep clients from wandering beyond appropriate areas. *Safety and Infection Control*
- 113. (4)** Assessment of acute medical/surgical care clients with restraints should include: when restraints removed /reapplied; skin and circulation; toileting; food/fluids; ranges of motion and client repositioning; client response; effect of restraints; continued need. *Safety and Infection Control*
- 114. (4)** Dilute prescribed IV calcium preparations in dextrose 5 percent in water. Never dilute calcium in solutions containing bicarbonate—precipitation will occur. Also don't give the patient with hypocalcemia calcium diluted in 0.9 percent sodium chloride because the sodium chloride may increase renal calcium loss. *Physiological Adaptation*
- 115. (2)** Always use IV 5 percent Dextrose in water (D5W) with calcium preparation. Never dilute calcium in solutions containing bicarbonate—precipitation will occur; if calcium is diluted in a 0.9 percent sodium chloride it may increase renal calcium loss. *Physiological Adaptation*
- 116. (2)** Lactated Ringers is a balanced electrolyte solution; free of reactions; plasma is the physiological (90 percent) of normal blood; Lactated Ringer's solution resembles the electrolyte composition of normal blood serum and plasma. *Physiological Adaptation*
- 117. (2)** Crystalloids include dextrose, saline, and lactated Ringer's solutions. This group of solutions is used for replacement and maintenance fluid therapy. *Physiological Adaptation*



- 118. (4)** Multiple myeloma is a malignant disorder in which immature plasma cells proliferate in bone marrow, forming single or multiple osteolytic tumors; symptoms include: vague pain in pelvis, spine, ribs, eventually becoming more severe and localized; pathological fractures, with decreased resistance to infection; anemia; eventually renal problems. Patients with multiple myeloma must be well hydrated to prevent precipitation of Bence-Jones protein in the renal tubules, which could cause renal damage. Recording fluid intake and output allows the nurse to determine whether adequate amounts of fluids are being taken in; because patients with multiple myeloma are at risk for developing bacterial infections, especially pneumonia, preventive measures must be taken; turning the patient to prevent skin breakdown and improve lung expansion should be done every 2–3 hours. *Physiological Adaptation*
- 119. (2)** Cold moist skin is one of the signs of shock. This finding indicates possible internal bleeding, which is a complication of autoimmune thrombocytopenic purpura; petechiae, bruising, and heavy menstrual flow are all symptoms of this disease. Antiplatelet antibodies are produced in the body; these attack the platelets, causing a decreased platelet count and increased risk of bleeding; this disease is a deficient number of platelets circulating in the blood; antibodies are directed to and coat the surface of the body's own platelets, making them more susceptible to destruction by phagocytic leukocytes. *Physiological Adaptation*
- 120. (3)** The patient and his parents should be questioned about the possible reasons for the increased number of bleeding episodes. They may need further education or counseling to prevent trauma exposure and thus reduce the number of bleeding episodes; hemophilia is a hereditary clotting factor disorder characterized by prolonged coagulation time, which can result in persistent and severe bleeding; the nurse should suggest ways for the boy to perform the activities of daily living without incurring further joint damage; non-aspirin based analgesics; patients with hemophilia should be encouraged to accept themselves and their disease. They should also be encouraged to be self-sufficient and to maintain their independence. *Physiological Adaptation*
- 121. (1)** Generalized pruritus may be the first and only symptom of Hodgkin's disease to appear for months. Along with lymph node enlargement, it is a common symptom of Hodgkin's disease; Hodgkin's disease is a malignant disorder of the lymphatic tissue marked by proliferation of constituent pruritus, enlarged lymph nodes (painless), epigastric pain, weight loss, fatigue, chills and fever, weakness, anemia, thrombocytopenia, respiration, infections, other infections. *Physiological Adaptation*
- 122. (3)** Access to healthcare is still one of the major problems in the United States. Infectious diseases account for 25 percent of all physician visits annually. Although many of the previously deadly communicable diseases have been conquered, new ones have emerged to take their place. *Physiological Adaptation*
- 123. (4)** Today, infectious diseases are not the leading cause of death even though there are individuals who die of these diseases; the toll on the economic status remains high due to the procedures, therapy, and research into the new infectious diseases. *Physiological Adaptation*
- 124. (1)** The transmission of communicable diseases depends upon the successful interaction of the infectious agent with the host and the environment. Changes in the characteristics of any of these three factors may result in disease transmission. There are four main categories of infectious agents that may cause infection or disease: bacteria, fungi, parasites, and viruses. Four factors influence the spread of disease: host resistance, immunity, herd immunity, and infectiousness. A human or animal may harbor an infectious agent. *Physiological Adaptation*
- 125. (4)** The nurse should have communication skills to help the family members with the grieving process; remaining calm and supportive of the family is very important; contact with the family is crucial; the family should be able to view the body if desired. When the nurse touches the body, it gives the family "permission" to touch the body also, and may help the family to integrate the loss. *Physiological Adaptation*
- 126. (4)** Early defibrillation is the single most important factor in determining survival from the cardiac arrest. If the time from the call is received, to the arrival of the defibrillator is longer than 8 minutes, virtually no one survives cardiac arrest. *Physiological Adaptation*
- 127. (3)** Questions must be open-ended, nonaccusatory, and nonconfrontational. The nurse encourages the patient to confide in him or her and indicates that the nurse is in a position to protect the patient's safety. *Physiological Adaptation*

- 128. (4)** The patient's head is lowered 15 degrees, and gastric contents are aspirated and sent for analysis prior to instillation of any substance. The unconscious patient will undergo endotracheal intubation, and oil-based lubricants must not be used. A poison is any substance that can harm the body, sometimes seriously enough to create a medical emergency. Poisons interfere with, but do not enhance, the normal biochemical processes in the body. Poisons damage the body by destroying skin and other tissues, overstimulating or depressing the central nervous system, and displacing oxygen on the hemoglobin. It is important to find out the route, type, and time of the poisoning. *Physiological Adaptation*
- 129. (3)** Cryoprecipitate contains clotting factors, including factor VIII, fibrinogen, and von Willibrand factor. The products in options 1, 2, and 4 will not replace the missing clotting factor. *Pharmacological Therapies*
- 130. (1)** Whole blood is used for this procedure in a milliliter:milliliter ratio. The volume utilized is usually twice the infant's calculated blood volume. The bilirubin level is significantly reduced. The product in option 2 is too concentrated for a double volume exchange transfusion. The products in options 3 and 4 are not used solely for an exchange transfusion procedure. *Pharmacological Therapies*
- 131. (3)** Incompatible medications can precipitate in the catheter causing an occlusion. Flushing well between medications prevents incompatible medications from mixing and forming a precipitate. The key in this question regards administering multiple medications. Medication administration is not a factor in these answer choices. *Pharmacological Therapies*
- 132. (4)** By definition the device must be placed in a central vein. Central veins lead directly to the heart. Even though options 1, 2, and 3 provide information about CVADs, these points do not define CVAD. *Pharmacological Therapies*
- 133. (1)** Chemotherapy produces bone marrow suppression thus decreasing the marrow's ability to produce red blood cells leading to anemia and fatigue. Bone marrow suppression is not the result of iron or folic acid deficiency. Exsanguination is direct blood loss. It may lead to anemia but is not caused by chemotherapy. *Pharmacological Therapies*
- 134. (3)** Ideally, a cancer cure will be elicited. If no cure is possible, cancer palliation prolongs useful life and reduces incapacitating symptoms. Limiting toxic chemotherapy side effects is a secondary goal of treatment. Early recognition and treatment of cancer enhances the cure rate. A cure is part of the main goal of therapy. A suitable quality of life is part of the main goal of cancer chemotherapy and is related to palliation. *Pharmacological Therapies*
- 135. (2)** Spironalactone is a synthetic steroid that competes with aldosterone for the mineralocorticoid receptor in the renal tubules. It exerts a mild antidiuretic effect by blocking sodium reabsorption in the distal renal tubule. The peak effect of the drug is not reached for 3 days (72 hours) thus it would not be the diuretic of choice to emergently treat pulmonary edema. There are numerous side effects, but very few true allergic reactions to the drug. There is no intravenous form of spironalactone. Prolonged therapy may result in hyperkalemia. *Pharmacological Therapies*
- 136. (3)** High potency topical corticosteroids, especially if used long-term, will cause hypopigmentation. Therefore, they should not be used on the face where hypopigmentation would be an issue. Hypopigmentation in these areas is less noticeable and less of an issue for a patient. *Pharmacological Therapies*
- 137. (2)** 40 drops per minute is 2 milliliters per minute. Two milliliters per minute for 60 minutes will provide the correct 120 milliliters per hour rate. The steps in options 1 and 4 will delay administration of the prescribed fluid. It is unnecessary to take the step in option 3. The nurse can calculate the correct drip rate. *Pharmacological Therapies*
- 138. (3)** To provide an arena of patient safety, especially when a potent agent such as potassium chloride is administered, it is wise to have double checking of the dose. Potassium chloride is relatively inexpensive. Double checking the dose does not perform the activities in options 2 and 4. *Pharmacological Therapies*
- 139. (1)** Complications of long-term TPN administration include gall bladder sludging, cholecystolithiasis (gall stones), cholestasis, and abnormal liver function tests. Pain associated with a MI is typically left-sided. This patient's history does not indicate a MI. The patient would exhibit respiratory distress. This patient's history does not indicate pneumonia. The patient is not exhibiting signs of infection. *Pharmacological Therapies*

- 140. (2)** Amino acids are the building blocks of proteins, the principal constituent of the protoplasm of all cells. Acids can act as weak buffers but are utilized in TPN for protein formation. Trace elements are cobalt, copper, chromium, fluorine, iron, iodine, manganese, molybdenum, selenium, and zinc. The drug used to maintain catheter patency is heparin. *Pharmacological Therapies*
- 141. (4)** Unbound or free drug is available to bind to a cell receptor and exert its effects. Hydrophilic drugs have difficulty crossing lipid membranes. The vast majority of drugs are either weak acids or bases. They are not pH neutral. Hydrophobic drugs will cross lipid membranes. *Pharmacological Therapies*
- 142. (2)** A drug with a high hepatic extraction ratio will have significant amounts removed during the first pass through the liver, thus reducing the amount of active drug available to the tissues. A reduction in dosage would further reduce the amount of bioavailable drug. A drug with a high hepatic extraction ratio will require an increase in dosage. *Pharmacological Therapies*
- 143. (3)** The number of sleep cycles experienced by the usual, non-exhausted sleeper is 4–6 cycles. *Basic Care and Comfort*
- 144. (2)** The maintenance of a regular sleep-wake rhythm is more important than actual number of hours slept. Some individuals can function well on 5 hours of sleep each night. *Basic Care and Comfort*
- 145. (2)** NREM sleep physiological parameters decrease or slow due to the drowsiness and relaxation. Systolic arterial pressure falls, cardiac output decreases and pulse rate decreases. *Basic Care and Comfort*
- 146. (4)** A quality indicator is a quantitative measure of an important aspect of care that determines whether standards are being met. It is a standard of performance. On a med-surg unit specific care indicators could include: medications errors, incisional wound infections, post-op incidence of pneumonia. The number of re-admissions with a primary diagnosis of CHF would be more likely to be institutional focused due to the high volume potential exceeding that of the unit activity in caring for those patients. *Coordinated Care*
- 147. (2)** Delegation is an effective method of workload distribution, as tasks are shared within a team *Coordinated Care*
- 148. (3)** Supervision involves appropriate delegation, while maintaining responsibility for the outcome. A supervising nurse who delegates tasks is still responsible for the outcomes. *Coordinated Care*
- 149. (4)** Indirect patient supervision may be accomplished through supportive technology such as: telemetry. Bed alarms and closed circuit monitoring. Loud speaker announcements are not appropriate means of communicating patient related information. *Coordinated Care*
- 150. (1)** The area of role mastery involves vocational, sexual and family roles; therefore, the nurse would ask about previous successes. The other questions relate to self-esteem. *Coordinated Care*
- 151. (4)** The nurse should assess role and relationship patterns thoroughly for an elderly client because losses associated with aging and changed social roles may affect the client's health status. This area has a strong effect on self-esteem, cultural and spiritual needs, and social support patterns. *Health Promotion and Maintenance*
- 152. (3)** When exploring the precipitating events for a crisis, the nurse looks at recent events. The precipitator is often a loss. This loss may seem trivial to the nurse but has deeper meaning for the client. *Psychosocial Integrity*
- 153. (1)** Capillary hemangioma ("stork bites") may affect the upper eyelids, bridge of the nose, or nape of the neck in a neonate. They result from vascular congestion and disappear as the skin thickens. *Health Promotion and Maintenance*
- 154. (1)** There are several types of elder abuse: physical abuse, physical neglect, psychological abuse, psychological neglect, financial abuse, and violation of personal rights. Not maintaining safety would be a form of neglect. *Psychosocial Integrity*
- 155. (4)** A competent client must give permission prior to taking photographs. The exact form of the permission depends upon the agency, but most require written documentation. *Psychosocial Integrity*
- 156. (2)** The difference between in-hospital, partial hospital and outpatient psychiatric care is the controlled environment in which therapy occurs. In-hospital treatment shelters the person from whatever is perceived as painful and frightening to them and provides an opportunity for stabilization. Day care, or other partial-hospitalization programs, provides structure for an intensive support and intervention. The home is adapted to provide a supportive therapeutic environment. *Psychosocial Integrity*

- 157. (3)** Obsessive compulsive disorder typically has periods when symptoms worsen for no apparent reason. The client should be taught to seek treatment for an adjustment in medication and help in modifying the behavior. If the symptoms do not respond to treatment, the client may require hospitalization. Many psychiatric facilities provide varying levels of care, such as day care, evening care and residential programs. *Psychosocial Integrity*
- 158. (2)** After formulating specific diagnoses as part of the planning process, the nurse uses critical thinking skills to establish priorities by ranking them in the order of their importance. *Coordinated Care*
- 159. (1)** is correct. Autonomy is the individual's right to self determination and in this case the nurse is playing a supportive role to facilitate the decision making. (2, 3 and 4 are incorrect). Confidentiality is the duty to protect privileged information. Justice is the principle of treating other fairly. The ethical principle of truthfulness is veracity. *Coordinated Care*
- 160. (1)** These antibiotics can eradicate intestinal flora involved in the enterohepatic cycling of contraceptive steroids. The agents in options 2, 3, and 4 do not interact with OCs. *Pharmacological Therapies*
- 161. (1)** Staff must have a significant amount of data relevant to their efforts in providing nursing care to be able to accurately analyze the appropriateness of care. The information is unit based and focus rather than on the institution as a whole. *Coordinated Care*
- 162. (4)** The nurse can plot the usual weight and height on a chart. Determination can be derived by further questioning this client or eating patterns, health status, as well as the psychosocial assessment. *Health Promotion and Maintenance*
- 163. (1)** The Colorado growth and development chart begins while in infancy and continues in younger children. Other milestone parameters of growth and development are used to determine wellness and health. *Health Promotion and Maintenance*
- 164. (4)** The three basic orientations to wellness and illness are: a subjective feeling of well-being or ill health (the feeling-state orientation), an absence or presence of general or specific symptoms (symptom orientation), and a state of being able or unable to perform usual activities (a performance orientation). *Health Promotion and Maintenance*
- 165. (2)** Nurses applying this intervention strategy should work with families to choose behavior to be changed. Schedules should be developed of how to gradually move toward selected targeted health-generating behavior, and reinforcement contingencies should be set up. In order to attain family goals, a nurse-family contract with planned rewards for desired behavior and incremental successes may be implemented in order to promote responsibility for all family members. Contracting can be enjoyable for the entire family, with family members serving as important source of motivation for each other. Pender and associates (2001) suggest that operant conditioning works best if the behavior to be reinforced is countable, so that reinforcement may be used correctly. *Health Promotion and Maintenance*
- 166. (1)** For a family to be responsible for its own self-care, it needs to have an understanding of its own health status and/or health problems and the steps needed to improve or maintain its health. Self-care practices involved not only preventive practices, diagnosis, and home treatment of common and minor ambulatory health problems, but also all the procedure and treatments prescribed for the care of illness of a family member, such as giving medications, using special appliances, changing dressings, and carrying out special exercises and diets. *Health Promotion and Maintenance*
- 167. (1)** The client can expect to take a bowel preparation the day before the procedure. Often a clear liquid diet is required the day before the procedure and the client is NPO after midnight. Usually the procedure is done under conscious sedation. *Health Promotion and Maintenance*
- 168. (4)** It is important that if a lump be found, the physician should be contacted for an exam by a clinician. The lump may not be felt if position is changed but the lump will still exist and need to be evaluated. Breast tissue changes throughout the menstrual cycle so it is important to have the lump evaluated while it is felt. *Health Promotion and Maintenance*
- 169. (4)** The most therapeutic statement is number 4. Options 1 and 2 discount the client's concern, and option 3 does not elicit the client to talk more. *Health Promotion and Maintenance*

- 170. (1)** Transference—the experiencing of thoughts and feelings toward a person (often the therapist) that belong to a significant person in one’s past. Transference is a valuable tool used by therapists in psychoanalytical psychotherapy. The analyst assists the client in exploring these emotion-loaded areas by pointing out and interpreting the resistance in an effort to weaken the client’s defenses and bring repressed conflicts into the open. This enables the client to work through the situations to a more satisfactory conclusion. Finally, the analyst assists the client in converting newly won insights into everyday existence and behavior. *Psychosocial Integrity*
- 171. (3)** In a therapeutic nurse-client relationship, the focus is on the client’s needs, thoughts, feelings, and goals. The nurse is expected to get personal needs met outside this relationship. Genuineness, positive regard, and empathy are personal strengths in the helping person that foster growth and change in others. *Psychosocial Integrity*
- 172. (1)** Grief has been described as a normal response to a significant loss. It is the subjective feelings and affect that are precipitated by a loss. *Psychosocial Integrity*
- 173. (2)** Successful mourning consists of a task-based model that attempts to describe tasks that are involved in the process of mourning. (1) Accept the reality of the loss; (2) share in the process of working through the pain of grief; (3) adjust to an environment in which the deceased is missing; (4) restructure the family’s relationship with the deceased and reinvest in other relationships and life pursuits. *Psychosocial Integrity*
- 174. (3)** Irritable bowel syndrome is a functional disorder of motility (spastic colon). Many of the symptoms described for diseases of the lower intestinal tract are characteristic of a spastic colon or irritable bowel; the symptoms include diarrhea, constipation, abdominal pain, and gas; the difference between a spastic colon or irritable colon is that the spastic colon has no lesion; there is no tumor or ulceration. It is a functional disorder of motility, the movement of the colon; the pain is probably caused by muscle spasms in the wall of the intestine; emotional stress and upset are disrupting in this disease. *Physiological Adaptation*
- 175. (2)** The infections process can progress to respiratory complications; inflammation of the lining of the abdominal cavity, usually results when the digestive contents enter the cavity, as this material contains numerous bacteria; the spread of peritonitis throughout the entire abdominal cavity is impeded by adhesions; the fibrous tissue of the adhesions can serve to localize the inflammation; occurs after perforation of intestinal diverticula, peptic ulcers, gangrenous, gallbladders, others; the bacteria most frequently identified as causative agent in peritonitis is *Escherichia coli*; the patient acutely ill with peritonitis is usually very apprehensive and needs constant care. *Physiological Adaptation*
- 176. (3)** Narrow-angle glaucoma develops abruptly and manifests with acute eye pain and is a medical emergency. Halo vision, dull eye pain, and impaired night vision are symptoms commonly associated with open-angle glaucoma; caused by the alteration in the circulation and reabsorption of aqueous humor; may occur because of an abnormality of the trabecular meshwork (network) that impairs flow of aqueous humor into the canal of Schlemm. The resulting causes increased pressure in the posterior chamber. *Physiological Adaptation*
- 177. (3)** A cloudy-appearing lens is symptomatic of cataract development. As the cataract matures, the red reflex is lost. A sense of a curtain falling over the visual field is associated with detached retina. Eye pain and double vision are not associated with cataracts; a progressive clouding or opacity of the lens of the eye that interferes with the transmission of light to the retina, leading to painless loss of vision; cellular debris from the deteriorating lens escapes through the degenerating lens capsule into the aqueous humor and may contribute to obstruction of overflow of aqueous humor resulting in increased intraocular pressure. *Physiological Adaptation*
- 178. (4)** Effects of radiation therapy (head/neck) on the nutritional status of the client are: irritation of mouth, tongue, and esophagus, dry mouth, tooth decay; gum destruction, altered taste and smell, dysphagia. *Physiological Adaptation*
- 179. (2)** Radiation therapy—clients can receive external-beam radiation therapy (EBRT), or internal radiation therapy (brachytherapy) with implanted isotopes; it damages rapidly replicating local normal host cells along with cancerous cells; it is used to treat tumors that cannot be surgically removed and are sensitive to radiation exposure. *Physiological Adaptation*
- 180. (2)** Sputum samples should be collected early in the morning before the client eats or drinks. The client is not required to be NPO for 24 hours before the procedure. The client needs to be well hydrated to facilitate coughing up tenacious secretions. Using toothpaste or mouthwash should be avoided because they can affect the sample. The sample should be coughed up from deep within the lungs. Saliva should not be collected. *Physiological Adaptation*

- 181. (1)** Upon completing the incident report, the nurse should forward it to the nursing supervisor or designee per facility policy. The report should not be placed in the chart. There is a need for family notification to follow. The nurse does need to document the fall in the patient record, but not reference that an incident report has been written. *Coordinated Care*
- 182. (4)** If the client indicates a lack of understanding, it is the nurse's role to inform the physician so that questions can be answered. Answer(s) 1, 2 and 3 are incorrect. The nurse cannot answer the client's questions because of a lack of medical understanding and the definitions of nursing practice. Consent should not be signed until the client indicates satisfaction in understanding. The nurse should not gloss over or minimize the fact that a client indicates a lack of understanding. The nurse is responsible for ensure the client gets information required to then sign consent. *Coordinated Care*
- 183. (4)** is correct. The American Nurse's Association published standards of clinical nursing practice in 1973. These standards define a competent level of behavior in the professional nursing role common to all nurses engaged in clinical practice. *Coordinated Care*
- 184. (4)** Documented decisions made before illness strikes and communicated within a family and caregivers help to make the decision easier for organ donation at the time of death. *Coordinated Care*
- 185. (4)** There is a direct relationship between increasing dextrose concentrations in peripheral IV fluid and complications. Complications include vein irritation, discomfort, infiltration and extravasation with tissue damage, elevated serum glucose levels, and infection. *Pharmacological Therapies*
- 186. (1)** This action provides necessary information regarding the IV fluid itself. Although options 2, 3, and 4 are pertinent information, they are not applicable to the IV fluid itself. *Pharmacological Therapies*
- 187. (2)** These agents relax vascular smooth muscle, primarily in the venous system, thus reducing the volume of blood returning to the atria of the heart. This reduces cardiac work load by decreasing intra-myocardial wall tension and intraventricular work. After-load is the resistance against which the left ventricle has to work to eject blood. Myocardial contractility is the ability of the myocardial muscle to shorten itself. Venous vasodilators have no effect on sodium and water retention or excretion. *Pharmacological Therapies*
- 188. (1)** The drug (solute) is dissolved in a liquid (solvent). Efficacy is the ability to produce a desired effect; effectiveness. Potency is the degree of power or strength. Affinity is a close relationship, mutual attraction, or similarity; the tendency of a drug to combine with its receptor. *Pharmacological Therapies*
- 189. (3)** Celecoxib is a non-steroidal anti-inflammatory drug that blocks cyclooxygenase-2 production (COX-2) but does not block cyclooxygenase-1(COX-1) production. Thus it does not have the side effects of drugs that block COX-1 isoenzymes. These effects include decreased platelet aggregation, renal effects, and GI complications such as bleeding and perforation. Aspirin and ibuprofen block COX-1 isoenzymes. Aspirin and ibuprofen are often taken to relieve arthritis pain. Celecoxib is not prescription-strength aspirin. *Pharmacological Therapies*
- 190. (2)** The loop of Henle is the most active part of the nephron tubule. Loop diuretics are the most effective agents. Thiazide diuretic work on the distal tubule. Potassium sparing diuretics work on the collecting duct. Carbonic anhydrase inhibitors work on the proximal tubule. *Pharmacological Therapies*
- 191. (2)** Culturally competent care includes providing the client with items from their culture, such as food choices. The nurse must understand the culture to provide this type of care. Unless the nurse knows the client's fluency in the English language, it would be difficult to make an appropriate choice between options 3 and 4. Thus, there is no basis for selecting them as the answer to this question. Rabbis are the spiritual head of the Jewish, not Chinese, religious community. *Psychosocial Integrity*
- 192. (2)** The extended family is considered a source of strength, support, and emotional stability for the Mexican-American family. Alternative healers and specific foods also may be important to the state of health. *Psychosocial Integrity*
- 193. (4)** RAS is essential to consciousness. The reticular activating system (RAS), with its many ascending and descending connections to other areas of the brain, monitors and regulates incoming stimuli. The RAS maintains, enhances, or inhibits cortical arousal. *Psychosocial Integrity*



- 194. (4)** Light, machine noise, and multiple caregivers lead to a sensory overload. Too much stimuli at one time for the individual to process. *Psychosocial Integrity*
- 195. (1)** Psychiatric Emergencies crisis is when an individual's functioning has become severely impaired as in an individual who contemplates suicide. Developmental crisis occurs in response to a situation that triggers emotions related to unresolved conflict in one's life; anticipated life transition crisis is a normal life cycle transition that may be anticipated, but the individual has no control; dispositional crisis is an acute response to an external situation stressor. *Psychosocial Integrity*
- 196. (2)** The ability to channel frustrations into an acceptable behavior shows that coping and problem-solving (punching a bag is superior to punching the girlfriend). Option 1 demonstrates avoidance behavior which does not help the patient problem-solve affectively. Option 3 is avoidance by staying away from the girlfriend. Option 4 does not show increased coping behavior. It demonstrates object removal before violence occurs (avoidance). *Psychosocial Integrity*
- 197. (1)** Role ambiguity occurs when the client does not know what to do or how to do it. The client's statement best matches option 1. Option 3 is the opposite of option 1. there is no data in the question stem to support options 2 or 4. *Psychosocial Integrity*
- 198. (2)** The goal of identifying alternative coping strategies is most directly related to the diagnosis of ineffective individual coping. *Psychosocial Integrity*
- 199. (2)** Planning for discharge begins during the admission assessment based on anticipated discharge and self-care needs. *Coordinated Care*
- 200. (3)** The basis of a health maintenance organization (HMO) is the voluntary enrollment of a population of persons to an organization emphasizing health promotion and health maintenance. The HMO has a specific set of providers of care, so that choice of providers is limited to those within the HMO. The emphasis is on wellness, and keeping persons healthy so as not to need acute care services. *Coordinated Care*
- 201. (1)** The administration of Rhogam and rubella is recommended at different times due to the effect on the immune system. Mild cold symptoms is not a contraindication to rubella. The client does not receive the vaccination if immune or if the client has already had the disease and is therefore immune. *Health Promotion and Maintenance*
- 202. (2)** Rubella poses a threat to a developing fetus and thus pregnancy is not recommended within 3 months of receiving the vaccine. The vaccine is not a live virus so contact with immunocompromised individuals is not contraindicated. Contact with newborns is not impacted by the immunization. *Health Promotion and Maintenance*
- 203. (3)** A common reaction to the DTP is drowsiness. Headache and photophobia are common reactions to the Hepatitis B vaccine and joint pain is a common reaction to the MMR vaccine. *Health Promotion and Maintenance*
- 204. (3)** Before state asylums, people with mental illness in the United States lived on streets, homes for the poor or ailing, jails or with their families. State Hospitals then were created (1800s) to protect vulnerable people from the stress of society and provided the services they needed. Today, the client with a mental illness is with their families (caregivers) in the community. *Health Promotion and Maintenance*
- 205. (4)** Nursing interventions used to establish a nurse-family relationship include establishing trust and listening actively. *Health Promotion and Maintenance*
- 206. (2)** Using Cognitive therapy principles option 2 is the only strategy that attempts to question the client's faulty thinking. Cognitive theories, an outgrowth of different theoretical perspectives, including the behavioral and the psychodynamic, attempted to link the internal thought process with human behavior. A distorted belief is the basis of cognition. People with faulty beliefs cause errors in judgment that become habitual errors in thinking. These individuals incorrectly interpret life situations and jump to inaccurate conclusions. *Health Promotion and Maintenance*
- 207. (2)** In therapeutic communication, the nurse chooses the best words to say and uses non-verbal behaviors that are consistent with these words. Choosing the best response begins with assessing the meaning of the patient's communication. Showing understanding and respect is important in developing a trusting therapeutic relationship. *Health Promotion and Maintenance*

- 208. (1)** Aminoglycoside antibiotics can affect renal function leading to elevated levels of digoxin and digoxin toxicity. Potassium chloride is commonly administered with digoxin to insure an adequate level. Dosage of KCl is determined by laboratory studies. The agents in options 3 and 4 do not affect renal function. *Pharmacological Therapies*
- 209. (2)** An additive effect the ability to achieve a response is the total of both agents. When drugs act in opposition to each other the response is termed antagonistic effect. Both these choices are saying the same thing. When a second drug enhances the effect of the first drug the term is synergistic effect. *Pharmacological Therapies*
- 210. (2)** The respiratory center sensitivity to carbon dioxide (CO<sub>2</sub>) is diminished thus the patient fails to respond to increasing CO<sub>2</sub> levels by increasing the depth and rate of respirations. Respiratory depression may occur any time an opiate analgesic is administered. Oxygen does not stimulate the respiratory center. Hyperoxygenation, especially in patients with chronically elevated CO<sub>2</sub> levels such as with chronic obstructive pulmonary disease will actually respond to oxygen with apnea. Pain management is necessary at all times. The patient requires careful evaluation and ongoing assessment. *Pharmacological Therapies*
- 211. (2)** These receptors are located in different parts of the CNS. Opiate administration results in altered perceptions including brain and spinal cord analgesia, sedation, euphoria, and autonomic stimulation. Nociceptors are found in the skin, joints, viscera, and other peripheral tissues. Prostaglandins contribute to sensations of pain. The opiate receptors in the CNS do not release prostaglandin. The CNS opiate receptors are not up-regulated by opiate analgesics. Opiate analgesics block the receptors sensation of pain. *Pharmacological Therapies*
- 212. (2)** The rhythmicity of breathing is controlled by respiratory centers located in the medulla oblongata of the brain. These inspiratory and expiratory centers control the rate and depth of respiration to meet the body's metabolic demands. *Physiological Adaptation*
- 213. (3)** Broad-spectrum antibiotics are indicated under medical supervision as a prophylactic treatment against lung infections, particularly during winter months. Influenza injections are regularly recommended for patient with chronic chest problems; patients with lung disease should not smoke any substance. *Physiological Adaptation*
- 214. (2)** Expiration is a passive process in which the intercostals (rib) muscles and the diaphragm relax, causing the chest cavity to decrease in size and forcing air from the lungs. *Physiological Adaptation*
- 215. (1)** Beta blockers decrease the release of insulin in response to hypoglycemia and mask the symptoms normally associated with hypoglycemia. Option 3 is the effect of the beta blocker. It happens regardless of whether the patient has diabetes mellitus. Beta blockers do not have this effect. *Pharmacological Therapies*
- 216. (3)** Testosterone administration prior to completion of bone growth leads to premature closure of the epiphyseal line, inhibiting normal bone growth. The opposite effect than in options 1 and 2 occurs. Testosterone is prescribed to treat delayed puberty. *Pharmacological Therapies*
- 217. (1)** Health Beliefs is the primary factor. The susceptibility and seriousness of the disease are perceived factors that are not dependent on fact but on the person's personal beliefs. Both of these individual perceptions become the "readiness" factors leading to the perceived threat of a disease. In this model, there are modifying factors (demographic, sociopsychological, and structural) that are posited to modify perceived susceptibility, severity, perceived benefits versus costs, and cues to action. Cues to action refer to the immediate stimuli needed to trigger recognition in the person's mind of the susceptibility and seriousness of a disease (the threat), and the need for taking action to reduce the threat. *Health Promotion and Maintenance*
- 218. (4)** The Occupational Safety and Health Administration (OSHA), an agency of the U.S. Department of Labor, publishes and enforces regulations to protect healthcare workers from occupational injuries. Using proper precautions, and wearing appropriate personal protective equipment, and avoiding carelessness in the clinical area will place the caregiver at significantly less risk for injury. Prevention remains the primary goal. *Health Promotion and Maintenance*
- 219. (3)** Poor dietary practices leading to obesity is a primary example of the results of an unhealthy lifestyle. Many Americans are overweight and gain weight as they grow older. About 55 percent of American adults are overweight, with men more likely to be overweight than women. Being overweight is linked to high blood pressure, heart disease, certain types of cancer, arthritis, breathing problems, and other illnesses. Cardiovascular disease is now recognized as a disease of childhood, as obesity increases in young children. *Health Promotion and Maintenance*



- 220. (4)** Family nurses are challenged to assist the family unit in identifying areas of health risk, in establishing relevant health goals, and in planning for lifestyle changes that will continue as an ongoing family commitment. For health-promotion planning to be effective, it must be compatible with the family's cultural beliefs and practices. Awareness of the family's cultural interpretation of health, illness, and healthcare is essential prior to embarking on specific goal-oriented interventions. In addition, family goals should be recorded and then prioritized by the nurse and family together. Major sources of stress, along with any recent or current family developmental or situational transitions, also require consideration prior to intervention. Collaboration of the entire family in expressing concerns, setting health goals, and planning for lifestyle modifications should increase the effectiveness of the nursing interventions. *Health Promotion and Maintenance*
- 221. (1)** Protein intake should be 12–14 percent of the daily diet. A combination of meat proteins with those in vegetables and grains should meet the protein requirements for most all senior adults. Total fat content of a senior adult's diet should be 30 percent with no more than 10–15 percent being saturated fat. Carbohydrates should contribute 50–58 percent of the senior's diet with no more than 10 percent being concentrated sweets. *Health Promotion and Maintenance*
- 222. (2)** Common side effects of alendronate sodium include gastrointestinal symptoms of heartburn, nausea, and abdominal pain. Photophobia, rash and hypotension may be side effects of other medications but are not associated with alendronate sodium. *Pharmacological Therapies*
- 223. (1)** The vital capacity of the lungs at 85 years of age is 50–65 percent of someone who is 30 years of age. This is evidenced by a decrease in the elder's capacity to inhale, hold their breath and to exhale. The cough reflex is decreased in the elderly and the sensitivity to stimuli that would cause a cough is decreased. Respiratory movements in the elderly are impaired by kyphosis, not lordosis. The kyphosis is caused by calcification of the vertebral cartilage and stiffens the chest wall, impairing respiratory movement. Lungs in the elderly have lost elasticity and remain hyperinflated even after exhalation. *Health Promotion and Maintenance*
- 224. (1)** Tactile losses in the elderly mean that they will need to be very careful when using heating pads, hot water bottles, or ice packs. They may not be able to determine when they are being burned or frostbitten. Use of these devices should be discouraged. Assistive devices such as canes or walkers may help the elderly maintain their balance and walk safer. They should also walk more slowly so that they have careful placement of their feet and fully touch the surface before taking the next step. Frequent position changes will help avoid decubitous ulcers and are especially important for the bedridden or wheel chair bound. If tactile sensation is decreased it will take a firm gentle pressure by the nurse to allow the elder to sense their presence. *Health Promotion and Maintenance*
- 225. (2)** The genogram organizes family history data, and is used to identify an actual or potential and familial health problems. This is a tool the nurse can use to gather information about the family. A genogram interview makes the family feel the nurse is interested in the whole family. This genogram is one part of a comprehensive clinical assessment of the family. *Health Promotion and Maintenance*
- 226. (1)** Once data is collected it must then be analyzed according to the thresholds which will define whether or not a problem exists. If a problem exists, then the process moves into the problem solving steps. *Coordinated Care*
- 227. (3)** The response that immunizations protect against potential diseases that may occur in the USA is the most relevant, best answer. All of the responses are correct, however, 1 and 2 are not specific to the client and 4 is blaming in nature and should be avoided. *Safety and Infection Control*
- 228. (1)** All four options will be affected to some degree; however, the most likely description will first occur in body image changes (how the patient views himself). This will further impact self-concept, personal identity and self-esteem. *Psychosocial Integrity*
- 229. (3)** Following a major surgery as breast removal, the patient will not feel "whole" due to loss of a "valued" area of the body removed. This change in how she view her body post-operatively can cause altered body-image. Light stressors may call forth a person response and mobilize an individual's strengths, resulting in a positive or negative response. With a negative response, self-concept diminishes. *Psychosocial Integrity*
- 230. (2)** Anorexia nervosa is a self-endured starvation that results from an individual's fear of "fatness." Patients with anorexia nervosa have an altered internal concept of themselves in that every time the person looks at himself/herself all they see is a fat body image. *Psychosocial Integrity*

- 231. (3)** Crohn's disease is characterized by periods of remission and exacerbation. During the active phase, inflammation and ulceration are the main physiologic events; they result in narrowing of the lumen and formation of adhesions. The primary complications of Crohn's disease that must be monitored are sepsis, peritonitis, hemorrhage, and mechanical obstruction; the ulcerations associated with Crohn's disease cause adhesions and incarcerations to form. *Physiological Adaptation*
- 232. (3)** Diabetic ketoacidosis (DKA) is an emergency situation that occurs in type I diabetes. The nurse must recognize the signs of DKA in its early stages to prevent the patient from entering into a coma. High blood glucose level (greater than 400 mg/dl) results in increased thirst, nausea, vomiting, abdominal pain, fatigue, polyuria to anuria, elevated temperature, signs of dehydration, flushed face, rapid and thready pulse, and hypotension. *Physiological Adaptation*
- 233. (2)** The data indicate impaired renal function, which is expected in chronic renal failure (CRF). Because the kidney does not filter or excrete water or waste products, these substances accumulate in the blood, and there is a high risk of fluid volume excess. *Physiological Adaptation*
- 234. (4)** Gentamicin is an aminoglycoside. Because this class of drugs is highly nephrotoxic, the nurse would monitor kidney function closely while the patient is receiving gentamicin. Maintaining BUN, which is a direct measure of kidney function, within normal range is a desired outcome. *Physiological Adaptation*
- 235. (3)** Nursing advocacy includes the encouragement and support of independent patient decision-making. It is built upon the ethical principle of autonomy and self-determination. *Coordinated Care*
- 236. (2)** This is the best response, as it allows for an open-ended response. The other questions may have some validity, but do not allow for the expression and caring of this statement. *Reduction of Risk Potential*
- 237. (4)** A client with tuberculosis needs to take his medication as ordered, not just when he feels bad, otherwise resistance to the antibiotics may develop. Most tuberculosis treatment regimens are at least 2 months, and may last up to a year. Even with treatment, a client may relapse, as tuberculosis can be reactivated. *Reduction of Risk Potential*
- 238. (4)** In order to provide supervision direct presence and some degree of participation is required. Availability needs to be maintained to be a resource as needed, provide direct assistance and staff guidance. *Coordinated Care*
- 239. (3)** Effective time management refers to the quality of doing the right task correctly. Efficient time management may require utilizing multiple techniques in order to accomplish the task, but refers to the use of the correct resource(s) for the right task. *Coordinated Care*
- 240. (1)** Time management is the facilitation of the best use of time. *Coordinated Care*
- 241. (1)** A nurse midwife may be appropriate prior to delivery, but would not initiate care in the postpartum period. An adoption agency would only be a referral choice if the mother is giving the child up for adoption. Referral to planned parenthood for family planning services for a minor child would necessitate consent of a parent or guardian. Therefore, a referral to a home care agency with maternal-infant services for education and initiation of community services is the best choice. *Coordinated Care*
- 242. (1)** There are no charges to the family or donor's estate for organ donation. Organ donation does not disfigure the donor, and funeral arrangements such as open caskets do not have to be altered because of the donation. Often families of patients with massive head injuries who become brain dead are given the opportunity to donate organs because the other organs are still functional. The donor's information is confidential and not communicated to the recipient under normal circumstances. *Coordinated Care*
- 243. (1)** The American Nurse's Association in addition to defining practice standards is responsible for promoting nursing roles and interests as key members of the healthcare team. *Coordinated Care*
- 244. (1)** The nurse has a duty to correctly administer medications to the correct patient. Lack of verification of identity is a failure to follow procedure, thus a breach of duty. *Coordinated Care*
- 245. (1)** Forced treatment without consent could result in battery charges, which is offensive touching. Options 2, 3 and 4 are incorrect. Slander is a false, malicious statement that injures a person's reputation. Defamation is to damage one's reputation by either slander or libel. Perjury is deliberate false testimony under oath. *Coordinated Care*

- 246. (4)** Medication administration as a general anticipated component of care is covered by the general consent to treatment signed on admission. Options 1, 2 and 3 are incorrect. The general consent is not a blanket consent for any/all treatment. Investigative and surgical procedures require specific informed consents. *Coordinated Care*
- 247. (4)** An incident can involve anyone within the confines of a facility or on the facility property. *Coordinated Care*
- 248. (4)** Ethical decision making is accomplished by a process that takes all general and unique factors of a particular situation into consideration. A decision is arrived at based on the current reality of the situation. Choices 1, 2 and 3 are individual steps of the entire process. *Coordinated Care*
- 249. (3)** Ethics committees do not have a role in judgment of a situation or individual's performance. Choices 1, 2 and 4 are incorrect as they are primary ethics committee's functions. *Coordinated Care*
- 250. (2)** Mrs. T's reason for admission is weakness and a fall. Priority concerns in assessment would be to identify any intrinsic or extrinsic factors that lead to her fall. Her interest in reading, while may be important in determining possible activities to incorporate in her care plan while in the hospital is a lesser priority. *Coordinated Care*
- 251. (1)** Priority setting involves making a decision based on information obtained through a thorough assessment process. *Coordinated Care*
- 252. (2)** In instances of suspected child abuse, the nurse advocate has a responsibility to the patient to convey the concern verbally to the physician, in writing through complete factual documentation, and by following the facility's protocol for processing of such a suspicion. *Coordinated Care*
- 253. (3)** The nurse advocate will explore the patient's decision with him, support his decision-making authority, and encourage a discussion between the patient and his daughter regarding his wishes in order for these wishes to be honored. *Coordinated Care*
- 254. (4)** In exploring options for assistance to the family from the available community health services, the nurse is facilitating the family's caregiving and assisting them in meeting the patient's needs at home. As terminal illness has not been established, hospice is not yet an appropriate option. Institutionalized care may be needed later, but for now the family should be assisted in their desire to care for the patient at home. *Coordinated Care*
- 255. (4)** The financial institution and types of banking services used are not necessary information for discharge planning. Assisting with insurance questions and options, transportation options and arrangements, and caregiver availability and need are all appropriate areas of discussion during discharge planning. *Coordinated Care*
- 256. (2)** A red blood cell transfusion is used to correct anemia in patients where the low red blood cell count must be rapidly corrected. RBC transfusion will not correct a low platelet count. RBC transfusion will not correct a low white blood cell count. Packed RBCs contain very little plasma and thus, only a small amount of albumin. This amount will not correct low albumin levels. *Pharmacological Therapies*
- 257. (2)** This is needed to utilize the correct type of donor blood and to match the donor product with the patient. Incompatible matches would result in severe adverse events and possible death. The tests in options 1 and 3 are unnecessary. The test in option 4 is utilized to determine the patient's blood type and presence of antibodies to blood antigens. It does not determine donor blood compatibility with the patient. *Pharmacological Therapies*
- 258. (1)** The AHA's "Patient Bill of Rights" is applicable in the acute care setting. While other adaptations have been made and documents formed for other types of facilities and healthcare settings, this particular document is specific to the acute care setting. *Coordinated Care*
- 259. (1)** The provision of considerate and respectful care to patients is upheld by nurses in their code of ethics and in the AHA's "Patient's Bill of Rights." The challenges to providing this care are often related to the availability and cost of the care. *Coordinated Care*
- 260. (2)** This leader is exhibiting an autocratic leadership style. Laissez-faire leadership is passive without overt leadership. Democratic leadership takes information and suggestions from participants for leadership decision-making. Diplomatic leadership is a communication style, not a style of leadership. *Coordinated Care*
- 261. (4)** Computer access to confidential records should be guarded for the privacy of the patient. Unauthorized access to information by those not requiring access or by visitors/non-employees in a healthcare institution is considered a breach of privacy and confidentiality. *Coordinated Care*

- 262. (4)** Confidentiality of patient information has been upheld in the legal system of the United States as both a legal and ethical obligation of healthcare personnel. *Coordinated Care*
- 263. (3)** A neurologist would evaluate this patient for a possible CVA. A gastroenterologist works with patients with digestive problems, a physiatrist works with patients with rehabilitation needs, and a pulmonologist would work with patients with respiratory problems. *Coordinated Care*
- 264. (4)** There is not the availability of several choices in the immunizations arena. The research and development of even one vaccine is expensive and lengthy. Further, the immunizations may only be given together if outlined by guidelines such as the CDC's Advisory Council on Immunization Practice(ACIP) and must only be given under the umbrella of a prescriber's directive. *Safety and Infection Control*
- 265. (1)** A crisis is characterized by severe disorganization precipitated by failure of customary coping mechanisms or lack of or failure of usual resources. A stressor may be an event or event(s) extrinsic or intrinsic that combines with other factors to bring about the crisis situation. Depression and/or hypomania may result from sustained crisis situations and ineffective resolutions. *Psychosocial Integrity*

# NCLEX-RN Practice Test 3

**Directions:** For each of the following questions, select the choice that best answers the question or completes the statement.

1. Two toddlers are playing at daycare. One child suddenly takes a toy from the other. A nurse should recognize this behavior as:
  1. aggressive.
  2. egocentric.
  3. imitation.
  4. centration.
2. When assessing a preschooler who is engaging in magical thinking, a nurse would expect to identify which of these thought patterns?
  1. "I can't play outside because it is raining."
  2. "God will make it stop raining."
  3. "I can make it stop raining."
  4. "Maybe it won't rain tomorrow."
3. A preschool child tells the nurse about her friend named "Cassi" who comes to play when she gets home from daycare. The parents shake their head "no" and explain to the nurse that their child has started talking about this friend that doesn't exist. A nurse should recognize this behavior as indicative of:
  1. purposeful lying.
  2. absence of other social interactions.
  3. need for a pet.
  4. creation of a friend.
4. When assessing the language skills of a child, a nurse would expect to identify six-to-eight-word sentences in which of the following children?
  1. an 18-month-old child
  2. a 24-month-old child
  3. a 3-year-old child
  4. a 5-year-old child
5. When teaching a pregnant woman about the expected enlargement of her abdomen, the nurse should include which of the following?
  1. She will not be able to feel the fundus at 10–12 weeks.
  2. At 20–22 weeks, the fundus will be halfway between the symphysis and umbilicus.
  3. At 28 weeks the fundus will be one finger breadth above the umbilicus.
  4. At 36 weeks the fundus will be just below the ensiform cartilage.
6. When a pregnant woman says to the nurse, "I bought some cream to try and bleach this brown line on my stomach" the best response by the nurse would be:
  1. "That line is called striae gravidarum and is normal in pregnancy."
  2. "The cream will have no effect on the brown line and may hurt your baby."
  3. "That line is called melasma and will disappear on it's own after the baby is born."
  4. "One of the skin changes in pregnancy can be a brown line down your abdomen and is normal."
7. When a pregnant woman expresses concern that her forehead is getting darker, which of the following interventions is most appropriate for the nurse to recommend?
  1. Teach her make-up may help mask the increased pigmentation.
  2. Explain it will go away.
  3. Tell the woman it is normal.
  4. Avoid sun exposure.

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8. Which of the following behaviors, when displayed by a pregnant adolescent, would indicate to the nurse that the adolescent is experiencing body image disturbance related to effects of pregnancy on appearance?
1. begins wearing maternity clothing during second trimester
  2. wears restrictive clothing to conceal changing body
  3. agrees to gain recommended weight
  4. buys supportive bra to accommodate breast enlargement
9. While a client is undergoing a paracentesis, the client suddenly develops hypotension as the peritoneal fluid is being drained. Which of the following is an appropriate action of the nurse?
1. Increase the drainage rate.
  2. Slow the drainage rate.
  3. Monitor the blood pressure.
  4. Document the blood pressure.
10. Which clients with the following diagnoses might warrant fecal occult blood testing?
1. cerebral bleeding
  2. tracheal bleeding
  3. gastrointestinal bleeding
  4. vaginal bleeding
11. Which of the following statements by a client who has undergone an outpatient esophagogastroduodenoscopy indicates adequate understanding of post-test instructions?
1. "I will need someone to drive me home."
  2. "I can drive myself home after the test."
  3. "I can eat and drink right after the test."
  4. "I will take Tylenol for a fever."
12. If a client has been suctioned, how long should the nurse wait before drawing an arterial blood gas?
1. 5 minutes
  2. 10 minutes
  3. 15 minutes
  4. 20 minutes
13. After obtaining an arterial blood gas from the radial artery of a client on Heparin therapy, how long should the nurse hold pressure on the injection site?
1. 1 minute
  2. 5 minutes
  3. 10 minutes
  4. 25 minutes
14. A client's drug toxicity panel reveals a toxic level of Valium (diazepam). Which of the following responses by the nurse is appropriate?
1. "Do you realize that high a level could kill you?"
  2. "Please share with me why you took so much Valium."
  3. "You took enough Valium to kill a horse!"
  4. "I bet you drank alcohol to swallow the Valium."
15. Which is the most appropriate assessment technique the nurse can use to examine the prostate gland?
1. inspection
  2. auscultation
  3. percussion
  4. palpation
16. A woman who is breast-feeding develops swelling in her breasts. What is the most likely reason for the swelling?
1. mastitis
  2. cysts
  3. fibroadenoma
  4. papilloma
17. Human papilloma virus is associated with which condition?
1. gonorrhea
  2. genital warts
  3. genital herpes
  4. syphilis
18. When an elder adult presents with depression, the nurse would expect to identify all of the following clinical manifestations except:
1. difficulty remembering things.
  2. inability to concentrate.
  3. increased amount of sleep.
  4. withdrawal from others.

- 19.** An elder client has incontinence, confusion, anorexia, weakness, and a normal temperature. A nurse should recognize these signs and symptoms as indicative of:
1. pneumonia.
  2. congestive heart failure.
  3. urinary tract infection.
  4. myocardial infarction.
- 20.** When an elder client is experiencing musculoskeletal physiologic changes of aging, which of these interventions should receive priority in the client's plan of care?
1. Maintain adequate calcium intake.
  2. Place commonly used items within easy reach.
  3. Provide assistive devices to extend arm reach.
  4. Exercise as tolerated every day.
- 21.** Which of these strategies would the nurse include when planning care for an elder client with incontinence?
1. P.O. fluids at will.
  2. Administer diuretics in the afternoon.
  3. Pelvic muscle exercises.
  4. Routine hygienic care.
- 22.** The teaching plan for a pregnant woman whose pre-pregnant weight makes her obese should include which of the following instructions?
1. You should gain 28–40 pounds (12–18 kg).
  2. You should gain 25–35 pounds (11–16 kg).
  3. You should gain 15–25 pounds (7–11 kg).
  4. You should gain 15 pounds or less ( $\leq 7$  kg).
- 23.** Which of these strategies should a nurse anticipate when caring for a laboring woman who has an anthropoid pelvis?
1. Prepare for a vaginal birth.
  2. Anticipate Cesarean section.
  3. Administration of IV oxytocin.
  4. Prepare for a precipitous labor.
- 24.** When reviewing the chart the nurse notes the fetus of a laboring woman is in a transverse lie. The nurse should anticipate which part of the fetus delivering first?
1. the shoulder
  2. the occiput
  3. the buttocks
  4. the sinciput
- 25.** Which of the following would the nurse include when teaching a pregnant woman about the onset of labor?
1. "You may experience an increase in fatigue about 24–48 hours prior to labor."
  2. "If you develop a 'bloody show' you can expect labor to begin in 12–24 hours."
  3. "If your 'bag of water' breaks, labor will begin almost immediately."
  4. "If your contractions go away with a hot shower, you may be in false labor."
- 26.** The major principle to consider in the use of a cane is to:
1. ascertain that the client is able to bear weight on the affected extremity.
  2. assess whether the client is able to walk and advance the cane and the unaffected extremity at the same time.
  3. assess total measurements of the client so that the client can have some learning ability on the cane.
  4. have the support person always walk on the client's unaffected side.
- 27.** A client is recovering from back surgery and will need to be fitted for a brace before leaving the facility. The nurse must observe the client closely for:
1. deformities of the back.
  2. weakened muscles of back, arms, and legs.
  3. cardiac output, especially pedal pulses.
  4. evidence of skin breakdown at pressure points.
- 28.** Continuous passive motion devices (CPM) are ordered by the physician. These devices are set for the following:
1. speed, flexion, extension, involving the leg.
  2. speed, disease, condition of leg.
  3. skin condition hydration of body.
  4. knee bend.
- 29.** Which priority intervention is first when inserting an indwelling foley catheter?
1. aseptic technique
  2. instilling water into balloon
  3. inserting the catheter to the point where urine flows
  4. taping catheter tubing to the leg

- 30.** A 78-year-old male has a continuous bladder irrigation ordered following a TURP. The rationale for this order is to:

  1. prevent infection.
  2. maintain dilute urine decreasing irritation.
  3. deliver medication into the operative site.
  4. keep the urine flowing to prevent clot formation.
- 31.** A indwelling catheter for a male client is correctly taped to:

  1. the inner thigh.
  2. under the thigh.
  3. on the lower abdomen.
  4. on the umbilicus.
- 32.** Which type of contracture is most commonly seen in patients recovering from a prolonged CVA hospitalization?

  1. extension contractures
  2. flexion contractures
  3. twisted contractures
  4. fibrotic contractures
- 33.** A patient has problems ambulating secondary to “foot drop.” A “foot drop” is what type of contracture?

  1. foot in plantar flexion
  2. foot in plantar extension
  3. ankle with twisted flexion
  4. hip with a fibrotic contracture
- 34.** Venous stasis that occurs with decreased muscular contraction when a patient is on bed rest (immobility) predisposes him/her to:

  1. respiratory acidosis.
  2. orthostatic hypotension.
  3. decreased cardiac workload.
  4. deep vein thrombosis.
- 35.** While bathing an adult client, the nurse observes slight bruising on the client’s forearm. The nurse plans to document this assessment of the client’s integumentary system as:

  1. sebaceous.
  2. ecchymosis of the dermis.
  3. sebaceous cyst.
  4. epidermal abrasion.
- 36.** An adult client from West Africa is hospitalized following abdominal surgery. On the second postoperative day, the client refuses a complete bath by the nurse. The nurse should:

  1. tell the client that it is hospital policy.
  2. ask another nurse to assist in giving the client a complete bath.
  3. negotiate with the client for a partial bath as his culture may influence his hygiene practices.
  4. contact the charge nurse and ask for advice on how to accomplish the bath with this client.
- 37.** The nurse is caring for a 76-year-old client who is seen in the clinic because of dry, scaly skin. An appropriate question for the nurse to ask during the assessment of this client is:

  1. “Does the area cause itching?”
  2. “Do you find that you have more bruising?”
  3. “Is your skin warm to the touch?”
  4. “Have you noticed any moles on your skin?”
- 38.** When teaching a client about the use of a diaphragm, the nurse should include which of the following?

  1. The diaphragm should be used without a spermicide.
  2. Use a spermicide if it has been more than two hours since insertion.
  3. Leave the diaphragm in place for 6 hours after intercourse.
  4. Minor discomfort may be experienced during intercourse.
- 39.** When obtaining a health history from a client who has been using a diaphragm for two years, which information should a nurse recognize as the most pertinent?

  1. history of 10-pound weight loss
  2. client is 6 weeks post-partum
  3. occasionally checks placement during use
  4. reports a popping sensation during insertion
- 40.** When teaching clients about the mechanism of action for intrauterine devices, which of the following should the nurse include?

  1. They prevent ovulation.
  2. They prevent implantation.
  3. They promote ovum migration.
  4. They alter or inhibit sperm migration.



- 41.** Which of these assessment findings, if identified in a client who had an intrauterine device implanted four weeks ago, should a nurse report to the physician immediately?
1. intermittent bleeding
  2. palpable string from cervix
  3. cramping
  4. fever, chills, and malaise
- 42.** Which of the following clients is *most* predisposed to getting a urinary tract infection?
1. a female diabetic
  2. a female epileptic
  3. a male diabetic
  4. a male epileptic
- 43.** Which micro-organism most commonly causes urinary tract infections in clients without structural abnormalities or calculi?
1. staphylococcus
  2. pseudomonas
  3. escherichia coli
  4. enterobacter
- 44.** Which of the following statements by a female client indicates adequate understanding of measures to prevent recurrence of a urinary tract infection (UTI)?
1. "I will take antibiotics until symptoms are gone."
  2. "I will decrease my fluid intake."
  3. "I will wipe back to front after urinating."
  4. "I will avoid taking bubble baths."
- 45.** When a patient is receiving a medication that is known to cause nephrotoxicity, which parameters should be monitored?
1. alanine aminotransferase (ALT) and aspartate aminotransferase (AST) levels
  2. intake and output levels
  3. balance when standing
  4. cognitive level
- 46.** Tinnitus can be a symptom of what kind of toxicity?
1. aspirin, a salicylate
  2. methotrexate, for arthritis
  3. infliximab (Remicade), the biologic response agent
  4. prednisone, a steroid
- 47.** A teenage patient is admitted to the hospital because of acetaminophen (Tylenol) overdose. Overdoses of acetaminophen can precipitate life threatening abnormalities in which of the following organs?
1. lungs
  2. liver
  3. kidneys
  4. adrenal glands
- 48.** A contraindication for topical corticosteroid usage in a patient with atopic dermatitis (eczema) is:
1. parasite infection.
  2. viral infection.
  3. bacterial infection.
  4. spirochete infection.
- 49.** In infants and children, the side effects of first generation over-the counter (OTC) antihistamines, such as diphenhydramine (Benedryl) and hydroxyzine (Atarax) include:
1. Reye's syndrome.
  2. cholinergic effects.
  3. paradoxical CNS stimulation.
  4. nausea and diarrhea.
- 50.** A nurse asks a client to describe the quality of pain currently experienced. Which is an expected term for the client to use?
1. severe
  2. stabbing
  3. intermittent
  4. chronic
- 51.** Which of the following would be the most appropriate goal statement for teaching a client with chronic pain how to use visual imagery?
1. The exercises will decrease the need for analgesia.
  2. The exercises will enhance the effect of analgesia.
  3. The exercises will decrease pain sensation.
  4. The exercises will allow for better rest periods.

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52. Pain in the elderly requires careful assessment because older people have which of the following characteristics?
  1. increased pain tolerance
  2. decreased pain tolerance
  3. are likely to experience chronic pain
  4. experience reduced sensory perception
53. Identify the expected output for a severely dehydrated client.
  1. increased
  2. decreased
  3. unaffected
  4. diluted
54. Which vitamin is deficient in the diet of a client diagnosed with scurvy?
  1. vitamin A
  2. vitamin B
  3. vitamin C
  4. vitamin D
55. What foods would most benefit a client with scurvy?
  1. oranges, broccoli, liver
  2. cereal, peanut butter, fish
  3. sweet potatoes, cheese, cantaloupe
  4. cheese, grain cereal, milk
56. A patient with advanced cancer of the stomach is undergoing surgery to take out part or debulk the tumor. This is known as \_\_\_\_\_ surgery.
  1. tertiary
  2. restorative
  3. curative
  4. palliative
57. When administering medication to terminal patients, the nurse should be less concerned about:
  1. addiction
  2. allergy
  3. tolerance
  4. side effects
58. Which of the following primary precautions is aimed at reducing the risk of breast cancer in a female 50 years of age and older?
  1. pap smear
  2. colonoscopy
  3. ultrasound
  4. mammography
59. A quick initial assessment for a patient with a suspected stroke should include:
  1. LOC, pupillary response, babinski reflex.
  2. cranial nerve testing.
  3. romberg test, gait.
  4. facial droop, slurred speech, pronator drift.
60. Testing for myasthenia gravis may include:
  1. Atropine.
  2. Tensilon (edrophonium).
  3. Prostigmin (neostigmine).
  4. Mestinon (Pyridostigmine).
61. The RN is caring for a patient with migraine headaches. The RN will know that medication teaching has been effective when the patient states:
  1. "I should take Tylenol (acetaminophen) every day, even if I don't have a headache."
  2. "I should take Imitrex (sumatriptan) only if I have a headache."
  3. "I should take Phenergan (promethazine) every day, even if I don't have a headache."
  4. "I should take Cafergot (ergotamine with caffeine) only if I have a headache."
62. The RN is caring for a patient with a C6-C7 fracture and quadriplegia. The care plan will include:
  1. mandatory mechanical ventilation.
  2. assisted coughing.
  3. Trendelenburg positioning.
  4. suctioning every 2 hours.
63. The kind of man who beats a woman is a man:
  1. from a minority culture in the lower income group.
  2. from a majority culture in the middle-income group.
  3. who was never allowed to compete as a child.
  4. from any walk of life, race, income group, or profession.

- 64.** A batterer is usually someone who:
1. grew up in a loving, secure home.
  2. was an only child.
  3. was physically or psychologically abused.
  4. admits they have a problem with anger.
- 65.** A client asks about the effects of taking amitriptyline (Elavil), a tricyclic antidepressant. The nurse would tell the client:
1. "You will get a feeling of euphoria one hour after taking the medicine."
  2. "You will sleep better if you take the medicine early in the morning."
  3. "You may have jitteriness for the first two weeks you take the medicine."
  4. "You will not notice any improvement in your mood for about 7–10 days."
- 66.** A client who has been diagnosed with depression asks whether there is anything besides medication to help. The nurse's best response would be:
1. "Medication has been shown to be the only effective method to improve depression."
  2. "Daily exercise, such as walking for 20 minutes, is effective in mild depression."
  3. "Drinking a cup of coffee three times a day will decrease depression and give you energy."
  4. "Getting ten hours of sleep per night will help the depression."
- 67.** Child neglect is difficult to properly diagnose because:
1. specific standards of care are hard to understand.
  2. cultural variations exist in attitudes about childrearing and discipline.
  3. there is a direct relationship between poverty and neglect.
  4. physical injuries caused by neglect are difficult to detect.
- 68.** When assessing an injured child, the nurse recognizes which finding as an indicator of possible child abuse?
1. The parents delay seeking help after the injury occurred.
  2. The mother states she had prenatal care for the entire pregnancy.
  3. A sibling has a chronic debilitating illness.
  4. The child is seen annually by the same healthcare provider.
- 69.** When assessing the sexual functioning of aging men, a nurse should expect to obtain which of these findings?
1. decreased refractory period
  2. increased physical need to ejaculate
  3. no change in amount of semen released
  4. increased time needed to obtain an erection
- 70.** When an elderly client with a chronic illness says to the nurse, "I don't seem to be able to have an erection anymore," the best response by the nurse would be?
1. "It is not uncommon for aging men to have difficulty having an erection."
  2. "Tell me what medicines you are taking for your illness."
  3. "Illness usually doesn't cause difficulties with sexual functioning."
  4. "I'll let the doctor know you'd like to talk to him/her about this."
- 71.** Which of these measures, if included in the plan of care for an elderly client in a nursing home, would be most effective to promote the client's sexual expression?
1. Discourage physical contact between nursing home residents.
  2. Discourage discussion of sexual concerns.
  3. Insist on having patient room doors open at all times.
  4. Allow socialization with sexual partners.

- 72.** When elderly clients report to the nurse that their sexual activity is less than desired because they experience pain with positions for intercourse, the nurse would expect to identify which of the following in their medical history?
1. COPD (chronic obstructive pulmonary disease)
  2. stroke
  3. arthritis
  4. diabetes
- 73.** When clients tell the nurse that when they have sex with their partner they are really thinking about someone else, the nurse should recognize this as indicative of which of the following coping mechanisms?
1. projection
  2. rationalization
  3. fantasy
  4. denial
- 74.** When a family member has very low self differentiation, which of the following behaviors would the nurse expect to identify?
1. personal autonomy
  2. retains objectivity when stressed
  3. distinguishes between thoughts and feelings
  4. emotionally reactive when stressed
- 75.** Which of the following concepts must the nurse understand when working therapeutically with a family triangle?
1. There is always a “victim.”
  2. All members of a triangle participate equally in maintaining the triangle.
  3. Triangles can exist without the active cooperation of all its members.
  4. A person’s position in the triangle remains constant.
- 76.** Which of the following behaviors by the nurse would indicate that the nurse is no longer therapeutic and has become a part of the family triangle?
1. feels sorry for another member of the triangle
  2. maintains emotional contact with each family member
  3. identifies the issues of the triangles in his/her family of origin
  4. realigns with specific family members in a planned strategy
- 77.** While you are working with a family, the husband becomes critical and intrusive. The best response by the nurse would be to:
1. say to the husband, “It makes me irritated when you are this critical.”
  2. say to the wife, “What happens to your insides when your husband interrupts with criticism?”
  3. say to both the husband and wife, “We’ll talk about this some more when you have calmed down.”
  4. say to the husband, “If this is how you behave at home I can understand why your wife feels the way she does.”
- 78.** Which of the following indicates a developing infection in a client who has had an open fracture?
1. purulent drainage at the site
  2. decreased sensation distal to the site
  3. petechiae on the upper thorax
  4. decreased circulation distal to the site
- 79.** Which of the following signs or symptoms by a client who has just had repair of a femur fracture indicates a fat embolus?
1. weak pedal pulses
  2. chest pain
  3. cool feet
  4. poor leg sensation
- 80.** Which of the following signs or symptoms is *not* indicative of a complication of fat embolism after repair of a femur fracture?
1. apprehension
  2. tachypnea
  3. cyanosis
  4. bradycardia

*Situation:* Paul Jones, a 40-year-old business man, was admitted to the hospital for diagnostic tests. He insists there is nothing wrong with him except a chest cold that he's having difficulty shaking off. His wife says he coughs a lot, has lost 15 pounds, and seems easily fatigued.

- 81.** What defense mechanism is Mr. Jones using?
  1. regression
  2. displacement
  3. denial
  4. projection
- 82.** Diagnostic tests revealed a mass in the left upper lobe of Mr. Jones's lung. He is scheduled to undergo a biopsy. When the nurse explains the procedure to him, he seems to have difficulty grasping what she is saying and asks questions such as "What do you mean I'm going to have surgery. What are they going to do?" His voice is tremulous. His respirations are noticeably rapid at 28, and his pulse is 110. The nurse should assess Mr. Jones's level of anxiety as:
  1. mild.
  2. moderate.
  3. severe.
  4. panic.
- 83.** The major components of self-concept include:
  1. depression, confusion, growth and development.
  2. body image, identity, self-esteem.
  3. body image, self-esteem, ideals of the world.
  4. self-esteem, roles, growth and development.
- 84.** What are the psychiatric nursing functions in primary prevention?
  1. health education, referral, support
  2. health education, in anatomy and physiology, symptom development of disease
  3. support of client/social contacts, improvement of environmental conditions
  4. improvement of environment; for example, housing, improvement of self-worth
- 85.** The nurse is teaching a type of cognitive therapy known as rational emotive therapy to the patient in an addiction recovery program. Which of the following is considered an inaccurate belief or value?
  1. One should stand up for his beliefs despite society disapproval.
  2. Serenity is dependent on achieving locus of control.
  3. Past experiences are not the most important predictors of present behavior.
  4. Adequacy is not a requirement for acceptance.
- 86.** Over the past six months, John, a previously ideal employee, exhibits the following behaviors: frequent absences from work, numerous somatic complaints, drowsiness, slurred speech, red eyes, disheveled appearance, strong mint breath odor. The employee health nurse's initial response should be:
  1. perform an assessment in a kind, forthright manner.
  2. obtain blood and urine specimens for drug testing.
  3. confront John firmly concerning his absences.
  4. obtain hair samples for toxicology.
- 87.** How often should IV tubing be replaced in the client receiving total parenteral nutrition?
  1. every 24 hours
  2. every 48 hours
  3. every 72 hours
  4. every 96 hours
- 88.** When a central venous pressure reading is taken, with which structure of the heart should the nurse align the manometer?
  1. left atrium
  2. right atrium
  3. left ventricle
  4. right ventricle
- 89.** A nurse cleansing a central venous catheter insertion site notices redness and yellow drainage at the site. What should the nurse do first?
  1. Observe the client for systemic infection.
  2. Document the findings.
  3. Notify the physician of the findings.
  4. Remove the central venous catheter.

- 90.** Which of the following nursing interventions would be most likely to achieve a sustained positive effect on an Alzheimer's unit?
1. calling the clients by their first or "childhood nicknames"
  2. group sharing of "lifestories" such as old time memories of Christmas and family events
  3. reading from current magazines and periodicals
  4. encouraging physical exercise
- 91.** A client seeks help to manage symptoms of extreme anxiety related to social situations. Which desensitization technique will be most effective in managing the anxiety?
1. Assist the client to identify past experiences that caused anxiety.
  2. Instruct the client to participate in activities that place the client in large crowds daily to promote desensitization.
  3. Guide the client to practice relaxation techniques while anxiety-producing situations are imagined.
  4. Provide a negative stimulus each time the client becomes anxious in a social setting.
- 92.** The nurse reports a case of suspected child sexual abuse. The report is later found to be unproven. The nurse is:
1. protected from prosecution.
  2. at risk for prosecution for slander.
  3. at risk to lose her license for making false accusations.
  4. guilty of slander and libel.
- 93.** A child reports that an adult friend has been taking photographs of the child without clothing. The nurse would:
1. tell the child that photographs are nothing to worry about.
  2. tell the child that it is not right to tell lies about adults.
  3. ask the child to bring the photographs to make sure the child is telling the truth.
  4. gather more details and report the incidence to child protective services.
- 94.** A nurse is teaching a nutrition course at the local retirement center. Due to the decreased peristalsis in older adults, many struggle with constipation. What recommendation can the nurse make to help prevent this common problem?
1. Increase vitamin E.
  2. Increase fiber intake.
  3. Decrease water intake.
  4. Take aspirin once a day.
- 95.** A 60-year-old male client is scheduled for a colon resection at 7 AM the next morning. What is the most important preoperative education the nurse can provide the client to decrease the client's risk of developing pneumonia postoperatively?
1. incentive spirometry
  2. eating soft food
  3. supplemental oxygen
  4. splinting the abdomen
- 96.** While at a health fair, a client indicates to the nurse that she will have a mammogram yearly, conduct self-breast exams monthly, and have her cholesterol checked yearly. This conversation indicates to the nurse that the client believes which of the following?
1. She is at high risk for breast cancer.
  2. She is at high risk for heart disease.
  3. She understands the need for health promotion activities.
  4. She understands the need for disease prevention activities.
- 97.** When documenting complete assessment findings, the nurse should include which data?
1. all data (normal and abnormal findings)
  2. positive findings only
  3. negative findings only
  4. general findings only

- 98.** What are the components of the partial physical assessment?
1. general survey, vital sign measurements, and assessment of specific body structures and systems
  2. vital sign measurements, height and weight measurements, and assessment of specific body structures and systems
  3. general survey, vital signs measurements, and a review of all body systems
  4. height and weight measurements and vital sign measurements
- 99.** Accurate auscultation depends on which of the following instrument characteristics?
1. a bell heavy enough to lie firmly on the body
  2. a diaphragm cover that is flexible
  3. tubing that is thin and flexible
  4. small, flat metal earpieces
- 100.** Advance directives are:
1. a source of information about client values and wishes when he/she is not able to express him or herself.
  2. an irrevocable listing of personal wishes.
  3. transferable from state to state.
  4. legal only if recorded in court proceedings.
- 101.** Your ER patient is a 10-year-old with contusions which may have been inflicted by a caregiver. As a nurse advocate to facilitate the patient's care, you would do all of the following except:
1. identify and document the patient's condition.
  2. tell the mother.
  3. follow your facility protocol for mandatory reporting of suspicion of child abuse.
  4. discuss your findings with the physician in charge.
- 102.** Case management services begin with:
1. implementation of a case management plan.
  2. monitoring of the case management process in order to change plans if needed.
  3. assessment.
  4. evaluation.
- 103.** "Plumbism" refers to:
1. akali ingestion.
  2. acetaminophen overdose.
  3. lead poisoning.
  4. iron ingestion.
- 104.** Which of the following measures is essential for the patient taking lithium?
1. complete blood count
  2. urinalysis
  3. drug blood level
  4. potassium (K+) blood levels
- 105.** An age 23, pregnant, client presents to your clinic for her initial prenatal visit. She is 16 weeks by menstrual history. Screening today will be based on the following rationale:
1. chlamydial screen if at high risk.
  2. rubella titer if no history of Rubella.
  3. routine fingerstick glucose screening.
  4. syphilis, GC, Chlamydia, ABO, RBC, RH, HbsAg, Rubella.
- 106.** The nurse will teach what administration measure to increase absorption of the drug in a client receiving Griseofulvin?
1. The medicine must be mixed with a high fatty food.
  2. Do not take the medicine with a large glass of milk.
  3. Take the medicine only on an empty stomach.
  4. Take the medicine with 8 oz of water.
- 107.** Your patient is considering participating in a multi-site trial of a new cancer medication. According to the "Patient's Bill of Rights," it is important for the patient to know that:
1. all costs of research are paid by the patient.
  2. he has the right to refuse to participate in research without fear of loss of care.
  3. the physicians will no longer be caring for him if he does not participate in the research.
  4. the research study is his only hope of treatment.

- 108.** You belong to a professional nursing organization that provides social, educational, and political venues for nurses. You are active in the organization for almost two years, during which time you meet and work with nurses from several different nursing agencies and healthcare institutions in order to achieve a variety of goals, including obtaining advice regarding a personal career choice. This is an example of:
1. professional nurturing.
  2. networking.
  3. mentoring.
  4. collegiality.
- 109.** You have access to patient laboratory reports on your work computer and have accessed one patient's current test results. You should:
1. not leave the results visible on the screen when you step away from the computer.
  2. not leave the results visible on the screen where a visitor to your unit may see them.
  3. always sign off the computer when it is not directly in use so that unauthorized persons may not access confidential information.
  4. all of the above.
- 110.** You are working in the emergency room when a patient is admitted with right-sided weakness and swallowing difficulty. The physician specialist who may be expected to evaluate this patient would be:
1. a neurologist.
  2. a gastroenterologist.
  3. a physiatrist.
  4. pulmonologist.
- 111.** A nurse teaching a community based class for a church on "Health in Today's World" is focused on healthy lifestyles. The nurse suggests the following as an example of a primary prevention care practice:
1. water aerobics for those with osteoarthritis.
  2. participating in physical therapy following a hip fracture.
  3. cardiac rehab status post open heart surgery.
  4. eating a diet moderately low in carbohydrates, low in saturated fat.
- 112.** The nurse is engaged in routine morning care of a client who received abdominal surgery for an acute bowel rupture two days ago. If the nurse's hands are not visibly soiled during the dressing change, what type of cleansing should be applied at the completion of care?
1. disinfecting with household bleach in 1::4 solution
  2. antiseptic gel based handwash
  3. soapy water scrub
  4. hexachlorophyl based cleansing solution
- 113.** The patient will receive the drug of choice for the treatment of trichomoniasis. The nurse reviews the client's history to determine no allergy to which antibiotic?
1. Ciprofloxacin
  2. Augmentin
  3. Tetracycline
  4. Metronidazole
- 114.** The nurse assesses that the client may need a restraint and recognizes that:
1. an order for a restraint may be implemented indefinitely until it is no longer required by the client.
  2. restraints may be ordered on a prn basis.
  3. no order or consent is necessary for restraints in long-term care facilities.
  4. restraints are to be periodically removed and range of motion and repositioning done.
- 115.** A confused 78-year-old client who has fallen three times in the past month is admitted to the hospital with a possible fractured hip. The priority nursing diagnosis for this client is:
1. impaired home maintenance management related to falls.
  2. anxiety related to possible outcomes and hospitalization.
  3. safety related to secure restraints while hospitalized.
  4. risk for trauma related to history of falls and confusion.



- 116.** One liter (1000mL) of 5 percent dextrose in 1/2 normal saline solution (D5/0.45%NaCl) is what type of IV fluid?
1. Iso-osmolar
  2. Hypo-osmolar
  3. Hyperosmolar
  4. Iso/hypo-osmolar
- 117.** If D5W is used continuously over several days, the IV solution becomes:
1. Hypo-osmolar.
  2. Hyperosmolar.
  3. Iso-osmolar.
  4. Iso-hyperosmolar.
- 118.** A client was taken to the emergency after a car accident. The client was losing a lot of blood. What are the advantages of the use of crystalloids versus colloids when there is an acute blood loss?
1. Colloids help stop bleeding.
  2. Crystalloids lower blood pressure rapidly.
  3. Crystalloids will raise the blood pressure rapidly.
  4. Colloids replace packed cells.
- 119.** Ms. Judd, aged 10, is admitted with seizure activity. Her electrolyte values are as follows: Na, 115mEq/L; K, 3.0 mEq/L; Ca, 8.0 mg/dL; and Mg, 1/0 mEq/L. Which imbalances must be controlled to reduce her seizure activity?
1. K and Ca
  2. Na and Ca
  3. Na and K
  4. Mg and K
- 120.** The most common sign of thrombocytopenia is:
1. petechiae.
  2. hemostasis.
  3. melena.
  4. hemarthrosis.
- 121.** Transfusion of which of the following blood components would therapeutically provide all of the coagulation factors?
1. cryoprecipitate
  2. random donor platelets
  3. fresh frozen plasma
  4. stored whole blood
- 122.** Which of the following clinical signs and symptoms would suggest an anemia secondary to vitamin deficiency rather than folic acid deficiency?
1. smooth, sore tongue
  2. palpitations
  3. paresthesias
  4. dizziness
- 123.** A client has a diagnosis of Idiopathic Thrombocytopenic Purpura (ITP). A CBC from today shows WBC 5000/mm<sup>3</sup>, Hgb 12.9 g/dl, and platelet count 7000/mm<sup>3</sup>. Which of the following measures should be implemented in caring for this patient?
1. coughing and deep breathing every four hours to prevent infection
  2. platelet transfusions to maintain platelet count above 20,000/mm<sup>3</sup>
  3. aspirin as needed to control temperature or chills
  4. stool softeners as needed to prevent constipation
- 124.** The transference of antibodies from mother to infant is known as:
1. active immunity.
  2. passive immunity.
  3. natural immunity.
  4. horizontal transmission.
- 125.** A constant presence of a disease within a population is referred to as:
1. epidemic.
  2. pandemic.
  3. endemic.
  4. herd immunity.
- 126.** The term used to describe the occurrence of one case of smallpox in a population in which it was considered to be previously eliminated is:
1. endemic.
  2. epidemic.
  3. pandemic.
  4. infectivity.

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- 127.** Nitroglycerin is usually administered to a patient with chest pain. Why?
1. Blood flow to the brain is increased.
  2. Nitroglycerin dilates the blood vessels and decreases the work of the heart.
  3. Blood vessels constrict and blood pressure is raised.
  4. It is easy to administer in unconscious patients.
- 128.** All of the following can cause cardiovascular emergencies, whether directly or indirectly, except:
1. changes in the inner walls of arteries.
  2. problems with the heart's electrical function.
  3. problems with the heart's mechanical function.
  4. complications that result from cardiovascular surgery.
- 129.** The primary cause of an emergency in most cardiac-related medical emergencies is due to:
1. reduced blood flow to the myocardium.
  2. cardiac arrest.
  3. loss of consciousness.
  4. breathing difficulty.
- 130.** The literal meaning of angina pectoris is:
1. a small heart attack.
  2. a pain in the chest.
  3. paralyzed chest muscles.
  4. breathing difficulty.
- 131.** Fresh frozen plasma (FFP) is administered to a patient to treat which of the following conditions?
1. bone marrow suppression caused by chemotherapy
  2. hemophilia A
  3. overwhelming sepsis
  4. disseminated intravascular coagulopathy (DIC)
- 132.** The physician orders 20 milliliters of a 5 percent albumin and lactated Ringer's solution to be administered immediately to a pediatric patient. A 25 percent solution of albumin product is available. What amount of 25 percent albumin and what amount of lactated Ringer's solution should the nurse prepare?
1. The physician's order cannot be fulfilled using the 25 percent albumin product.
  2. The nurse should ask the pharmacy for a 5 percent solution.
  3. The nurse will use 4 milliliters of albumin product and 16 milliliters of lactated Ringer's solution.
  4. The nurse will administer 20 milliliters of the albumin product and follow it will 20 milliliters of lactated Ringer's solution.
- 133.** A patient, who had been an active swimmer, needs a central venous access device called a port to be inserted for long-term medication administration. The patient asks the nurse about permitted activities. The nurse explains:
1. once the port insertion site has healed, the patient may resume swimming.
  2. the area near the port can never be immersed in water.
  3. the physician will have to discuss bathing options with the patient.
  4. an occlusive dressing over the port will permit showers but not swimming.
- 134.** Primarily, why would a patient receiving long-term chemotherapy benefit from placement of a central venous access device (CVAD)?
1. Because of the risk of infection in immunocompromised patients, the use of a CVAD is contraindicated.
  2. It is optimal for medication administration and nutritional support.
  3. He wouldn't. CVADs are seldom used for this purpose.
  4. It eliminates the need for frequent venous punctures.
- 135.** Which form of topical corticosteroid is the strongest?
1. an ointment
  2. a cream
  3. a spray
  4. a lotion

- 136.** A 5-year-old patient has atopic dermatitis (eczema). His pediatrician prescribes an antihistamine at bedtime. The desired effect is:
1. to treat concomitant allergies.
  2. to prevent post nasal drip.
  3. to treat the itch-scratch cycle.
  4. to prevent nighttime coughing.
- 137.** Many hospitals have restrictions regarding the qualifications of an RN to administer certain medications IV. A likely example would be:
1. antimicrobial agents.
  2. antiretroviral drugs.
  3. antifungal agents.
  4. antineoplastic medications.
- 138.** A pediatric post-operative patient has an order for morphine sulfate 2 milligrams IV every 6–8 hours as needed for pain. Morphine sulfate is available in a 10 milligram per milliliter concentration. To ensure the correct volume is administered, the nurse:
1. will draw up and administer 0.2 milliliters.
  2. should check with the pharmacy regarding the correct amount to prepare.
  3. wait and let the oncoming shift give the initial dose.
  4. ask the physician for further clarification of the order.
- 139.** A patient asks his nurse why his bag of total parenteral nutrition (TPN) is yellow. She explains the coloration is due to the addition of vitamins. What vitamins added to TPN are necessary for normal human functioning?
1. the fat-soluble vitamins: A, D, E, K
  2. arginine and lysine
  3. A, B, C, D, E, K
  4. the water soluble vitamins: B, C
- 140.** The body requires an energy source for cellular functions and protein for growth. If the body's intake of energy is too low, the body will use the protein as an energy source. Which of the following items are utilized to meet the body's energy requirements?
1. amino acids
  2. trace elements and glucose
  3. fat emulsion
  4. carbohydrates and fats
- 141.** Your patient has both liver and kidney disease. She takes several oral medications. You would expect the duration of action of these medications to:
1. decrease.
  2. increase.
  3. stay the same.
  4. be absent.
- 142.** Before administering digoxin (Lanoxin) to a patient, the nurse must:
1. have the patient not eat or drink for 4–6 hours prior to the dose.
  2. count the apical pulse for one full minute.
  3. give the patient a potassium supplement based on amount of urine output.
  4. insure the patient's blood glucose is normal.
- 143.** What is the best indication that a client is not getting adequate sleep?
1. amount of time the client sleeps or doesn't sleep
  2. the patient reports not sleeping well
  3. inability to concentrate
  4. general appearance
- 144.** The physiology of sleep is complex. Which of the following is the most appropriate statement in regards to this process?
1. Ultradian rhythm occurs in a cycle longer than 24 hours.
  2. NREM refers to the cycle most patients experience when in a high stimulus environment.
  3. The RAS is partially responsible for the level of consciousness of a person.
  4. The Basal metabolic rate causes the REM sleep in most normal activities.
- 145.** When a client is deprived of sleep, the nurse might assess such symptoms as:
1. elevated blood pressure and confusion.
  2. rapid respirations and inappropriateness.
  3. confusion and mistrust.
  4. decreased temperature and talkativeness.

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- 146.** The nurse needs restraints for a client and has a physician's order. She does not know the type to use with this client. The types are all except:
1. adult—jacket restraints.
  2. adult—belt restraints.
  3. adult—yellow straight jacket body restraints.
  4. adult—mitt, hand, or limb restraints.
- 147.** Three types of quality indicators include all of the following except:
1. structure.
  2. procedure.
  3. process.
  4. outcome.
- 148.** Delegation is *not*:
1. the indiscriminate assignment of work to others (dumping).
  2. giving orders (directing the flow).
  3. abdicating control or responsibility (laziness).
  4. all of the above.
- 149.** Nurses are responsible for providing patient care, but in nearly all care situations supervise others to accomplish patient care goals. Supervision, in the broad sense is:
1. having the responsibility of being boss.
  2. the active process of directing, guiding, and influencing the outcome of an individual's performance on a task or activity.
  3. directly observing an individual doing their job.
  4. a management responsibility only.
- 150.** As a staff nurse, you are assigned to care for a patient admitted with a back injury status post fall earlier in the day. The patient needs to be turned and cleaned, with fresh linens put on the bed. Two UAPs approach you, saying they are ready to provide this care. You answer "I'll supervise." The meaning of your comment is:
1. "I'll stand at the door and watch."
  2. "We'll do this together and I'll give you direction and feedback as we go. . . ."
  3. "I'll finish passing the meds, and then come to the room to make sure everything is okay."
  4. "I'll sign your time card at the end of the shift to verify your hours."
- 151.** A nurse is exploring the support system for a client who is experiencing a crisis. One of the reasons the nurse wants to know about the support system is to:
1. choose who can take over the responsibilities of the client.
  2. determine who should accompany the client to therapy sessions.
  3. decide whether the client is suicidal.
  4. determine whether the client should live alone or with someone.
- 152.** A client who is considering suicide after breaking up with a friend reports that he has no friends or family nearby. The nurse would consider which type of assistance best for this client?
1. group therapy
  2. individual counseling
  3. acute psychiatric unit
  4. a group home
- 153.** When determining whether elder abuse has occurred, the nurse recognizes that some signs of elder abuse may be similar to:
1. normal aging.
  2. clumsiness.
  3. poor nutrition.
  4. chronic illness.
- 154.** A client in his late 70s resides in a modest house where he has lived during the majority of his married life. His wife died about a year ago. Since then he has become socially isolated. Recently, a neighbor has befriended him and been buying his groceries. Each time the neighbor buys the groceries, she would keep some of the money for herself to cover her expenses. The neighbor's behavior would be classified as which type of abuse?
1. emotional
  2. financial
  3. psychological
  4. physical

**155.** A client goes to the Emergency Department with report of chest pains, shortness of breath, and extreme anxiety. Heart disease is ruled out, and the client is diagnosed with having a panic attack. When reviewing the client's chart, the nurse notes that the client has visited the Emergency Department with similar problems three times in the past year. The nurse discusses the panic attacks with the client. The client admits to having many panic attacks and asks for help. The nurse recommends:

1. a psychiatric consult and admission to an acute care facility.
2. the client go to a mental health clinic for outpatient care.
3. the client join a support group with people with similar problems.
4. the client enter a residential program where the environment is less stressful.

**156.** In the preinteraction phase of the therapeutic relationship the nurse's role is to:

1. review the goals of therapeutic relationships.
2. determine a plan of care.
3. perform a complete physical and psychological assessment.
4. determine the length the relationship should last.

**157.** Criteria for the nurse to use when setting priorities in the nursing care plan are all of the following except:

1. the nurse's perception of the basis of severity or physiological importance.
2. the patient's desires.
3. the physician's orders.
4. the patient's safety.

**158.** Nurse Jones stops at an accident scene to provide assistance. According to the ethical principle of beneficence the nurse will:

1. act in the patient's best interests.
2. allow patient choices.
3. consider the consequences of the actions.
4. make a decision.

**159.** An implication of Health Promotion Models (Pender) for family healthcare is:

1. "fear tactics" help families.
2. anxiety levels help families to move forward.
3. family health belief system is significant to health promotion.
4. most health promotion behaviors of the family have negative outcomes.

**160.** For health promotion, the family should be partners with the:

1. government.
2. healthcare professionals.
3. friends and relatives.
4. church.

**161.** The U.S. Department of Health and Human Services (U.S. DHHS) has stated the reasons for difficulties with the healthcare system. One belief is:

1. minority populations have increased access to Emergency Room and hospital care.
2. all U.S. citizens have access to insurance, whether private or government.
3. the level of education has nothing to do with healthcare.
4. access to and utilization of healthcare is a major problem in the United States.

**162.** Mr. Jarvis also has a high caffeine intake. How may this affect his sleep?

1. It should have no effect on sleep.
2. It may increase sleep latency and reduce total sleep time.
3. It may increase sleep latency and total sleep time.
4. It may decrease sleep latency and total sleep time.

**163.** Jessie Clemon, age 73, is a recent widow who has been having difficulty sleeping. What is the normal sleep pattern of a person of Ms. Clemon's age?

1. Sleep is consolidated and has a lower percentage of REM sleep.
2. Sleep is fragmented and typically includes a daytime nap.
3. Sleep is consolidated, but characterized by sleep latency.
4. Sleep is fragmented, but characterized by fewer arousals.

**164.** What is the family's role in health promotion?

1. exposure to health hazards
2. regular nightly cocktail(s)
3. improvement in lifestyle
4. an individual member with regular exercise

**165.** During a routine health screening, a client's bp = 180/120. What is the nurse's priority response to this finding?

1. Arrange to have the client admitted to the hospital.
2. Emphasize to the client the importance of follow-up with a physician.
3. Call 9-1-1.
4. Assess the client for stressors.

**166.** During a routine health exam, the client asks the nurse which foods he should eat on a low cholesterol diet. Which of the following could the nurse use as examples of foods consistent with a low cholesterol diet?

1. eggs, avocados, cottage cheese
2. chicken, breads, fruits, beans
3. steak, cheese, leafy vegetables
4. liver, yogurt, bread, rice

**167.** During a routine exam, the physician recommends to the client that she start performing Kegel exercises. The nurse knows that the purpose of Kegel exercises is to do which of the following?

1. strengthen the muscles that support the pelvic floor
2. strengthen the abdominal muscles
3. strengthen the muscles of the urinary system
4. strengthen the muscles of the respiratory system

**168.** Paraphrasing, restating, reflecting, and exploring are techniques used for the purpose of:

1. clarifying.
2. summarizing.
3. encouraging comparison.
4. placing events in time and sequence.

**169.** When the client makes the statement, "I get all balled up when I try to talk to him," and the nurse responds, "Give me an example of getting all balled up," the nurse is using the technique called:

1. exploring.
2. reflecting.
3. interpreting.
4. paraphrasing.

**170.** K., 34, is single and has very few close friends and relatives. He was very dependent upon his mother before her death, although he often complained about her intrusiveness. What statement best describes his risk for problems in resolving his grief?

1. He is at no particular risk since the death of parents is an expected event in one's life.
2. He is at low risk, since the task of young adulthood is to develop independence from the family of origin.
3. He is at moderate risk.
4. He is at high risk because he was dependent on his mother, demonstrated ambivalence toward her, and has a limited support system.

**171.** Which statement about palliative care could serve as a basis for the introduction a nurse gives to a client?

1. Palliation focuses on aggressive comfort care when cure is no longer the goal.
2. Clients receiving palliative care can realistically expect discomfort at life's end.
3. Palliation addresses emotional and spiritual pain more than physical pain.
4. Clients receiving palliative care are relieved of the responsibility of most care decisions.

**172.** The priority nursing measure for the client with a penetrating eye injury from a visible foreign body is to:

1. patch both eyes.
2. immobilize the foreign body and cover the eye.
3. irrigate the eye with copious amounts of water.
4. administer carbonic anhydrase inhibitors as prescribed.

**173.** A client is diagnosed with conductive hearing loss and asked how this occurred. The nurse should respond by stating that conductive hearing loss:

1. has an unknown etiology.
2. occurs as a result of damage to the hair cells of the Organ of Corti in the inner ear.
3. usually results from chronic exposure to loud sounds.
4. occurs as a result of damage to the ear structure.

**174.** A 42-year-old male client is admitted with a diagnosis of dehydration secondary to AIDS. The client states he has “difficulty eating and swallowing just about anything.” Weight evaluation reveals a 10-pound weight loss over a 3-week period. What could be the most likely etiology for the client’s chief complaint?

1. The client has been unable to go food shopping.
2. The client’s medication profile is causing him to develop anorexia.
3. The client could be developing an opportunistic infection.
4. The client has not been compliant with medication regimen.

**175.** Which of the following statements about cancer cachexia is true?

1. It is no different than simple starvation because the metabolic rate declines in response to tumor growth.
2. Cancer cachexia occurs as a result of chemotherapy but not radiation therapy.
3. Cancer cachexia occurs as a result of tumor-induced changes.
4. Cancer cachexia is only seen in clients who have limited caloric intake.

**176.** A 52-year-old male client being treated for cancer doesn’t understand why he is being given a “female hormone,” megestrol acetate (Megace), as part of the treatment regimen. He is afraid that it will alter his appearance. How would you respond to the client’s concern of altered body image?

1. Tell the client that the physical changes are only temporary.
2. Tell the client that this medication is used for its ability to stimulate appetite.
3. Tell the client that you understand his concern and that he should not take it.
3. Tell the client that the medication will be used for a short time and any effects will be self-limiting.

**177.** What interventions would be appropriate for a client admitted to the oncology unit for chemotherapy and radiation therapy who is experiencing dysgeusia?

1. Premedicate the client with an antiemetic.
2. Observe the client for signs of dehydration.
3. Use highly seasoned foods to stimulate taste buds.
4. Obtain an order for zinc and give with food or milk to treat symptoms.

**178.** The purpose of an incident report is:

1. to document who made a mistake.
2. to document what the mistake was.
3. to provide a permanent record of an incident to assist in refreshing the participant’s memory should details be needed at some point of the future.
4. to hide malpractice.

**179.** The requirements of informed consent are all of the following except:

1. the patient must be capable of making decisions.
2. once informed consent is given, it cannot be revoked.
3. the decision must be made voluntarily without coercion.
4. the patient must understand the potential risks and benefits that result from their decision making.

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**180.** In which of the following situations would a nurse have the responsibility to complete an incident report?

1. Mr. Jones refused to get out of bed this morning due to fatigue.
2. Mrs. Brown attempted to go to the bathroom herself, climbed over the side rails, and fell.
3. Mrs. Smith became dizzy when standing up from the chair and complained of blurred vision.
4. Mr. Jackson left the unit to buy a newspaper in the gift shop.

**181.** You are the nurse caring for an elderly gentleman in the hospital ICU who has suffered a traumatic brain injury. He has signed paperwork at a prior time for no cardiopulmonary resuscitation, for no ventilator, and for organ donation. His wife confides to you that she knows he wanted organ donation and if he should die that she would want this as part of his last wishes. Death appears imminent. You:

1. notify the physician and obtain orders for notification of the organ procurement organization in your community.
2. do nothing. You must wait for the gentleman to die to begin the organ procurement process.
3. notify the nursing supervisor.
4. call the coroner and obtain release of the body for organ harvesting at the time of death.

**182.** Normal saline IV fluid is the common name for:

1. 1.0% sodium chloride.
2. 0.9% sodium chloride.
3. 0.45% sodium chloride.
4. 0.025% sodium chloride.

**183.** A bag of IV fluid wrapped in dark plastic arrives from the pharmacy for a patient. The nurse knows this requires dark administration tubing. This is necessary to:

1. to prevent leakage.
2. alert the nurse that this is a dangerous medication.
3. prevent photolysis.
4. maintain federal HIPPA regulations regarding patient privacy.

**184.** Catecholamines, such as dopamine, dobutamine, and epinephrine are effective within a narrow pH range of:

1. 7.15–7.25.
2. 7.25–7.35.
3. 7.35–7.45.
4. 7.45–7.55.

**185.** A child who has juvenile rheumatoid arthritis exhibits rash, limp, loss of joint motion, and swelling over the large joints. A nurse should recognize these findings as indicative of:

1. impaired physical mobility.
2. activity intolerance.
3. pain.
4. body image disturbance.

**186.** Epoetin alfa (Epogen, Procrit) is a recombinant form of erythropoietin, a hematopoietic growth hormone produced by the kidneys. It is administered to patients undergoing chemotherapy to stimulate the production of:

1. platelets.
2. white blood cells.
3. red blood cells.
4. macrophages.

**187.** An adult incurs a scalp laceration secondary to a car accident. He asks about a tetanus booster. It has been almost 9 years since his last booster. You reply:

1. adults do not require tetanus boosters.
2. tetanus is a childhood disease.
3. adult boosters are only given every 10 years.
4. your protection may have diminished; it's best to receive a booster now.

**188.** Before acting upon the perceived nonverbal behavior of a client from Italy, the nurse must do which of the following?

1. Validate his or her perception.
2. Use a translator.
3. Get another nurse to assess the client.
4. Form a nursing diagnosis.



- 189.** The elderly client expresses difficulty sleeping because her spirit is disturbed because of sin in her life. Which intervention would have priority?
1. Call the chaplain and schedule a visit.
  2. Ascertain what religious practice is appropriate to the client.
  3. Pray immediately with the client.
  4. Administer sleep medications as ordered.
- 190.** Appropriate assessment data to collect when assessing a client's need for sensory stimulation includes:
1. race.
  2. age.
  3. gender.
  4. culture.
- 191.** A client is complaining of hand and wrist tingling and numbness. The nurse should appropriately conduct which of the following assessments?
1. general nerve assessment
  2. cranial sensory assessment
  3. cranial motor assessment
  4. peripheral nerve/motor assessment
- 192.** A crisis occurs when an individual:
1. perceives a stressor to be threatening.
  2. has no support system.
  3. is exposed to a precipitating stressor.
  4. experiences a stressor and perceives coping strategies to be ineffective.
- 193.** Betty's home is destroyed in a fire. Betty received no major injuries, but she is experiencing disabling anxiety after the event. This type of crisis is called:
1. dispositional crisis.
  2. crisis of anticipated life transition.
  3. developmental crisis.
  4. crisis resulting from a traumatic stressor.
- 194.** The nurse caring for a client who has been diagnosed as having generalized anxiety disorder tells another nurse, "I find myself feeling uncomfortable and anxious around the client. When he starts trembling, perspiring, and pacing, I find myself with cold, clammy hands and my pulse races. I start worrying whether I'll be able to help him stay in control." In such an interaction, the client will most likely experience:
1. claustrophobia.
  2. increased anxiety.
  3. fatigue.
  4. improved self-esteem.
- 195.** A patient's husband states that his wife is going through a midlife crisis. Which of the following behaviors would indicate this is most likely to be true?
1. buying a new wardrobe
  2. writing a novel
  3. wallpapering mother's room
  4. baking bread for neighbor
- 196.** Mrs. Upham does well during her orthopedic surgery for a hip fracture and discharge is anticipated in two to three days. You would expect:
1. discharge to home with home OT.
  2. discharge to a skilled nursing facility with PT and OT.
  3. a home care referral for skilled nursing only.
  4. no referrals to be necessary.
- 197.** Utilizing limited resources in an equally distributed way in order to provide everyone with some services that they need is related to which ethical principle?
1. beneficence
  2. justice
  3. autonomy
  4. nonmaleficence
- 198.** A 5-year-old child is undergoing long-term steroid therapy for asthma. Regarding immunizations for this child, the nurse knows that:
1. the child may not be vaccinated.
  2. the child may still be vaccinated.
  3. the child may receive all vaccinations except the polio vaccine.
  4. the child may receive only killed virus preparations.

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**199.** Which of the following sites is considered the safest site for administration of immunizations in infants?

1. vastus lateralis
2. right dorsogluteal
3. deltoid
4. left dorsogluteal

**200.** Contraindications to all immunizations includes which of the following?

1. immunosuppression
2. cold symptoms
3. previous fever with vaccination
4. redness at the injection site

**201.** A client is suffering from alcoholism. You educate his family members about alcoholism. This is an example of which type of nursing intervention?

1. interventions to help families with problem solving
2. interventions to establish a nurse-family relationship
3. interventions to change family behaviors
4. interventions to deal with destructive behaviors

**202.** You ask the family to recall all past concrete events that caused them worry, concern, or grief that were related to the alcoholic member of the family. You have a “family session” to discuss the personal growth and goals of each family member that has been affected by the alcoholic family member. You allow time for them to vent their feelings and respect the perspective of each family member. This is an example of which type of nursing intervention?

1. interventions to help solve family problems
2. interventions to establish a nurse-family relationship
3. interventions to change family behaviors
4. interventions to deal with destructive behaviors

**203.** A client is most concerned about the interactions that she has with her family, and she is in the process of establishing a positive view of herself. This client is meeting the developmental needs of the:

1. 12 to 20 year old.
2. early 20s to mid-40s age group.
3. mid-40s to mid-60s age group.
4. late 60s and older age group.

**204.** What is the rationale for the nurse making use of two congruent levels of communication when interviewing a client?

1. One statement may simultaneously convey different messages.
2. The mental image of a word may not be the same for both.
3. Many of the client’s remarks are no more than social phrases.
4. Content of messages may be contradicted by the process.

**205.** Which therapeutic communication technique is the nurse using when he says to Jerry, “Tell me about what was happening to you that led to your being hospitalized here?”

1. offering general leads
2. giving broad openings
3. encouraging description of perception
4. seeking clarification

**206.** Patients receiving theophylline for reactive airway disease (asthma) should be counseled that the following item can decrease the clearance of theophylline resulting in an increased serum theophylline level:

1. viral infection
2. e-mycin (erythromycin)
3. fever
4. penicillin

**207.** A patient is taking oral antacids for gastric discomfort. His lab work shows anemia and his physician orders twice daily ferrous sulfate (iron) therapy. You educate the patient that:

1. he should take iron on an empty stomach to prevent interference with iron absorption.
2. simultaneously taking iron and antacids will lessen the irritating effect of iron therapy on the gastrointestinal mucosa.
3. since there is no interaction between these agents he can take them when it is convenient.
4. he should have the physician discontinue the antacids until his anemia is resolved.

- 208.** The tricyclic antidepressant (TCA) amitriptyline (Elavil) has significant anticholinergic and sedative effects. Therefore, in addition to depression, it has also been useful in treating some patients with:
1. chronic pain conditions such as diabetic neuropathy and postherpetic neuralgia.
  2. idiopathic hypertrophic subaortic stenosis (IHSS).
  3. attention deficit, hyperactivity disorder.
  4. urinary retention.
- 209.** A patient returns to his room following abdominal surgery. The nurse should:
1. not administer any analgesics until anesthesia has completely worn off.
  2. administer pain medication as soon as the patient is settled in bed.
  3. encourage the patient to not take analgesics unless absolutely necessary to prevent respiratory depression and drug dependence.
  4. teach the patient to request pain medication before the pain escalates and becomes severe.
- 210.** Mr. Pips, aged 52, underwent a right lobectomy one day ago and is having difficulty handling mucous secretions. The nurse caring for Mr. Pips performs tracheobronchial suctioning on a p.r.n. basis. A potential complication of suctioning is lobar collapse. This can be avoided by:
1. using a large catheter the same diameter as the trachea.
  2. applying suction at high pressure to accomplish the procedure as quickly as possible.
  3. applying suction continuously for 30 seconds or more.
  4. using a catheter the size that does not occlude the lumen of the airway during application of suction.
- 211.** The partial pressure of oxygen in arterial blood ( $PO_2$ ) is proportional to the concentration of  $O_2$  because it is mixed with other gases. Keeping this fact in mind, at discharge from a Denver hospital that is at an altitude of approximately 5000 feet, which of the following is an expected acceptable discharge criterion for a person without COPD?
1. pH 7.3
  2.  $PaO_2$  65 to 75 mmHg
  3.  $PaO_2$  45 to 55 mmHg
  4.  $PaO_2$  80 to 100 mmHg
- 212.** Because the chest wall is softer in infants and children, they:
1. must inhale twice the amount of air to breathe.
  2. depend more heavily on the diaphragm for breathing.
  3. grunt and gurgle whenever they breathe.
  4. expend less energy than adults do when breathing.
- 213.** A 62-year-old patient with diabetes mellitus is started on the thiazide diuretic hydrochlorothiazide (Hydrodiuril) for mild hypertension. The nurse educates the patient:
1. to start administration of regular insulin.
  2. that thiazide diuretics are relatively risk free.
  3. hydrochlorothiazide will prevent diabetes complications.
  4. to follow his blood glucose values closely.
- 214.** Metformin (Glucophage) is an oral biguanide antidiabetic medication. The most common side effect is:
1. gastrointestinal disturbances.
  2. hypoglycemia.
  3. sleepiness.
  4. visual disturbances.
- 215.** The client states, "Heart disease runs in our family. My blood pressure has been high." The nurse determines that this is an example of the client's:
1. risk factors.
  2. active strategy.
  3. negative health behavior.
  4. health beliefs.
- 216.** In using the Stages of Health Behavior Change as a guide, the client is mostly likely to begin to accept health information during the:
1. contemplation stage.
  2. preparation stage.
  3. action stage.
  4. maintenance stage.

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**217.** When assessing the external variables that influence a client's health beliefs and practices, the nurse must also consider:

1. religious practices.
2. reactions to heart disease.
3. educational background.
4. income status.

**218.** The Family Risk Genogram is:

1. a biography of the family.
2. a family plan for change.
3. a health risk factor of the family and immediate relations.
4. a practice initiative.

**219.** Which documentation statement suggests an abnormal finding for Ms. Graves?

1. tympanic membranes shiny and pink
2. anteroposterior diameter 1:2
3. right breast slightly larger than left
4. bowels sounds auscultated in all four quadrants

**220.** Which nursing action would best prevent body image disturbance related to changes in appearance secondary to scarring of chickenpox lesions?

1. Administer varicella vaccine prior to exposure.
2. Administer varicella-zoster immune globulin upon exposure.
3. Administer oral antihistamines to prevent itching.
4. Administer aspirin for pain and inflammation.

**221.** A diabetic patient calls your clinic and reports her insulin is "clumpy." You advise her to

1. shake the vial vigorously to re-suspend the insulin particles.
2. warm the vial to room temperature to see if the clumps disappear.
3. discard the vial and open a new one.
4. gently roll the vial between her hands to re-warm the solution and re-suspend the insulin particles.

**222.** Which of the following counseling tips will help an individual maintain a positive body image?

1. You are strong and must stand alone.
2. Three "square" meals a day are necessary for health.
3. Wishing magically to lose weight.
4. Learn about good nutrition and exercise.

**223.** The cognitive body image distortion that anorexia will identify among patients with an eating disorder:

1. thinness equates with self-worth, self esteem.
2. being thin is being powerful.
3. being fat is more harmful than thin.
4. I'm not liked, because I am fat.

**224.** A client, who has type I diabetes mellitus, is experiencing nausea and vomiting. Which action indicates that he understands the "sick day rules" for diabetes management?

1. taking 2/3 of his normal insulin dose
2. abandoning his normal meal timing in favor of getting an extended period of sleep
3. drinking nondietetic ginger ale
4. monitoring his blood glucose every 6 hours

**225.** Nancy Kline, 56 years old, reports that she has felt fatigued and slow for the past month. She has gained 7 lb. in 3 weeks despite a report of not eating. Which question would the nurse consider asking the patient next?

1. "Are you losing clumps of hair when you brush your hair?"
2. "Do you frequently feel cold when other people in the same room are comfortable?"
3. "Have you experienced any tremors of your arms or hands?"
4. "Have you noticed any visual blurring or dizzy spells?"

- 226.** A client who is recovering from a spinal cord injury (SCI) has been referred for nutritional counseling due to weight loss. The client states, "If I eat too much, the weight will just stay on and I will become fat." How would the nurse best respond to this statement?
1. "It is important to continue to eat a diet high in protein, carbohydrates, and fiber to maintain optimal body function."
  2. "I know that you are concerned about weight gain, but you can always diet later on."
  3. "Let me know what your food preferences are and I will get you additional portions of whatever you like."
  4. "It is important to have extra nutrient stores in order to preserve skin integrity."
- 227.** A client is to undergo bone marrow transplantation (BMT) for treatment of leukemia and is receiving pre-procedure teaching with regard to nutrition. Which of the following nutritional support options would most likely be utilized for this client?
1. supplementation with enteral feedings to prevent catabolism
  2. oral feedings as soon as possible following BMT to prevent gastroparesis
  3. total parenteral nutrition (TPN) for a period of months to maintain nutritional balance
  4. insertion of a PEG tube following the GMT to maintain nutritional balance
- 228.** As a nurse assigned 20 patients on a med-surg floor you realize that the only way to be successful involves a coordination of team effort. Three strategies you'll use to accomplish this coordination are supervision, delegation, and assignment. Focused on assignment making, the nurse understands that:
1. delegation is not a type of supervision.
  2. assignment includes the shift of responsibility and accountability for the task for all staff involved.
  3. unlicensed assistive personnel (UAPs) are not assigned responsibility and accountability.
  4. UAPs are assigned responsibility and accountability.
- 229.** At the beginning of your 12-hour shift, you are responsible for deciding how your 12 med-surg patients' care needs will be met. In making your decision you will take into account all of the following except:
1. the number of staff available.
  2. the skill mix of staff available.
  3. the patient acuity.
  4. family questions.
- 230.** Your 85-year-old patient who is preparing for chronic dialysis asks you about how this will affect his quality of life. He has always been active in travel activities and socializing and wonders about who will help him make decisions as he progresses through the disease. You discuss with him the following regarding his healthcare:
1. need for a last will and testament.
  2. need for a living will and/or durable power of attorney for healthcare.
  3. no further written documentation needs at this time.
  4. need for designation of his physician as his decision maker.
- 231.** Challenging resource issues that nurses will deal with in professional practice are all of the following except:
1. family assistance in care.
  2. availability of community programs.
  3. availability of time.
  4. job availability.
- 232.** Mr. Hart is your patient who has a new diagnosis of lung cancer who is deemed terminally ill. During your assessment of discharge needs, you find that he has no available caregiver in the home but will need assistance with ADLs. You discuss with the discharge planner:
1. home care.
  2. adult day care.
  3. long-term care with hospice services.
  4. respite care.
- 233.** Referral to a home care agency requires:
1. physician's order.
  2. skilled nursing or therapy need of the patient.
  3. consent of the patient.
  4. all of the above.

**234.** Communication of one's wishes regarding organ donation is important because of all of the following except:

1. seventeen people each day die while awaiting organ donations.
2. a single tissue donor can provide donations for more than 50 people.
3. some people are waiting for more than one organ or tissue.
4. donor's wishes are not followed unless they are written.

**235.** A 35-year-old female patient on your hospital unit is awaiting a liver transplant. You are aware that all of the following are true except:

1. more than 85 percent of adult Americans approve of organ donation.
2. organ recipients are matched to donors by age and sex.
3. there are over 17,000 persons awaiting liver transplants in 2004.
4. there were under 6000 liver transplants in total in 2003.

**236.** A guardianship is all of the following except:

1. is court appointed.
2. handles any medical bills.
3. is a family member who helps with care and decision making.
4. may be temporary or permanent.

**237.** A nurse practice act defines the scope of nursing practice in a(n):

1. educational institution.
2. region.
3. state.
4. healthcare facility.

**238.** Formal, written consent is required for all of the following except:

1. gall bladder surgery.
2. insertion of a Foley catheter.
3. insertion of a pacemaker.
4. breast biopsy.

**239.** The nurse is responsible for obtaining patient consent for:

1. gall bladder surgery.
2. insertion of a Foley catheter.
3. insertion of a pacemaker.
4. breast biopsy.

**240.** Who is responsible for filling out an incident report?

1. the nurse manager
2. the nurse responsible for the error
3. the physician
4. the nurse that either witnesses an incident or discovers that it has occurred

**241.** An incident is defined as:

1. an error.
2. a negative outcome.
3. preventable.
4. an unusual occurrence.

**242.** You are assisting Mrs. Jeffries with hallway ambulation in the nursing home, and she tells you that she is afraid of what might happen to her if her heart failure worsens. "I don't want to have anything done to keep me alive," she tells you, "but my daughter tells me not to worry about it. If something happens, she will want me taken back to the hospital again. I don't want to be in an intensive care unit or put on machines. Can you help me please?" The ethical principle(s) involved here are:

1. autonomy.
2. veracity.
3. fidelity.
4. all of the above.

**243.** Which of the following presents a potential value conflict for the nurse caring for an older adult known to be a victim of elder abuse?

1. An abused older adult is admitted to the hospital because of injuries.
2. The abused older adult chooses to go back to the setting.
3. The abused older adult is placed in a nursing home for long-term care.
4. The abused older adult chooses to prosecute the offender.

**244.** All of the following are true as a nurse designates a task as high priority except:

1. priorities are physiological.
2. priorities are psychological.
3. if untreated could result in harm to the client.
4. involve a quick response to needs as determined by the nurse independently from the client involved.

**245.** At 11:00 AM Mr. P. is brought to the unit from the emergency room for admission. Lying on the transport cart, he is complaining of severe nausea and is dry heaving into an emesis basin. His wife and son are with him. What would be the most appropriate action for the nurse to take at this time?

1. Help get Mr. P. in bed and orient him to the bed controls.
2. Help get Mr. P into bed and begin to fill out the detailed admission assessment form.
3. Ask him whether he has valuables for the safe.
4. Help get Mr. P. in bed, properly positioned for comfort, and begin focused abdominal assessment targeting his nausea.

**246.** Which cranial nerve is responsible for chewing movement?

1. facial
2. abducens
3. trigeminal
4. hypoglossal

**247.** Which of the following signs or symptoms would alert a nurse to increasing intracranial pressure in a client with acute head trauma?

1. widening pulse pressure
2. narrowing pulse pressure
3. tachycardia
4. regular respirations

**248.** Which of the following terms describes a complication of rheumatoid arthritis, where the fingers become bent outward?

1. Hallux valgus
2. wwan-neck deformity
3. Boutonnière deformity
4. ulnar drift

**249.** Which of the following statements by a client indicates a need for further teaching by the nurse regarding prevention and treatment of Lyme disease?

1. "I will spray insect repellant on myself."
2. "I will tell my doctor about a bull's eye rash."
3. "If I see a tick, I will twist it out of my skin."
4. "I will avoid walking in tall grass."

**250.** A client who is an intravenous drug abuser had an appendectomy. He requests morphine sulfate for pain relief every hour, and it is only ordered every four hours. What is the appropriate response of the nurse?

1. Tell him it is only ordered every four hours.
2. Let him know his addiction may get worse.
3. Notify the physician of his request.
4. Instruct him on possible side effects.

**251.** Where should a nurse administer eye drops?

1. inner corner of the eye
2. outer corner of the eye
3. directly over the cornea
4. center of conjunctival sac

**252.** If a patient is deemed "incompetent" this means that:

1. he/she can't afford to pay the hospital bill.
2. he/she won't follow medical direction.
3. a court proceeding has declared him/her unable to make his/her own decisions.
4. as a nurse you have assessed that he/she is not making good choices or decisions.

**253.** A "DNRCC" code status means that:

1. the patient should not have their symptoms actively treated.
2. the patient's care is less priority than another patient whose code status is full code.
3. therapies and treatments have been limited to those that promote comfort.
4. it's no longer necessary to take the patient's vital signs.

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**254.** Your wandering Alzheimer's patient is in restraints as you start your shift on an acute care unit. As a nurse advocate, you:

1. remove the restraints on rounds and continue with rounds.
2. remove the restraints and instruct the patient not to wander.
3. call the physician for a prn sedative order for the patient.
4. assess the patient for safety issues and arrange for a family member to provide supervision.

**255.** As a profession, nursing in an advocacy role has an opportunity to impact all of the following except:

1. safe standards of practice.
2. safe staffing laws.
3. reasonable workloads.
4. increased cohesiveness of values in society.

**256.** As an advocate for the profession of nursing, the nurse will do all of the following except:

1. follow the standards of care for the patient group with which she/he works.
2. encourage appropriate persons to become nurses.
3. support safe working conditions for nurses.
4. encourage nursing research by nursing educators only.

**257.** Mrs. Gee is planning to be admitted to the hospital for elective surgery on Monday. When should her discharge planning begin?

1. when her physician writes the discharge order
2. at the time of admission
3. after surgery during the discharge planner's rounds
4. once the nurse is able to assess her post-operative status

**258.** A client has a total knee replacement. Which of the following statements indicates a need for further teaching before discharge?

1. I have four steps into my house and I know I'll be able to do that without my cane—right?
2. I will continue my exercise program with my therapist at home.
3. I will watch my knee for redness—I don't want an infection.
4. I will let my granddaughter pick my tomatoes—I know I shouldn't be bending over to do that.

**259.** The patient's right to provide informed consent to procedures includes which of the following procedures?

1. insertion of an internal defibrillator
2. surgical excision of a skin lesion
3. physical therapy exercises
4. all procedures

**260.** As your client enters the hospital, he signs a general consent form. This consent is used to document that he has given consent for:

1. all ongoing care in the hospital.
2. general treatment, but even after having signed the initial consent to treatment the patient continues to have the right to refuse treatment.
3. the administration of research medications and treatments.
4. a waiver of the confidentiality of his medical record.

**261.** A discharge planner may be:

1. a master's prepared nurse only.
2. a registered nurse or social worker.
3. an insurance company representative.
4. the physician.



**262.** DRG's are a patient classification scheme designed to:

1. assign patients with the same diagnosis to the same hospital unit.
2. monitor quality of care given to patients.
3. classify patients by diagnosis and relate this to the hospital's reimbursement.
4. a classification system used to determine occupancy in a hospital.

**263.** Your patient has been admitted to a four-bed room with three other roommates. What rights may be breached due to the setting?

1. right to refuse treatment.
2. right to examine and question his bill.
3. rights to privacy and confidentiality.
4. rights to information regarding diagnosis, treatment, and prognosis.

**264.** A new manager does not seem to trust that assignments will be completed as delegated without much supervision and direction. This style of management is called:

1. laissez-faire.
2. autocratic.
3. democratic.
4. diplomatic.

**265.** Important nursing management functions include:

1. education of staff and personnel.
2. provides performance feedback.
3. monitor the quality of nursing care.
4. all of the above.

## Answers and Explanations for Practice Test 3

For your reference, the appropriate review chapter is listed at the end of each answer explanation below.

1. (2) Toddlers engage in egocentric behavior. They believe what they want is all that matters and that everyone else wants them to have what they want. In this instance the child wasn't taking the toy to be aggressive but because they believed the other child would want them to have the toy. The toddler has no capacity to understand how this made the other child feel. Imitation would be mimicking other children or adult behaviors. Typically this is seen in facial expressions or in domestic activities such as picking up toys or housework. Centration is seen as the concentration on one aspect of a situation rather than the considering all the possibilities. An example of this would be a child refusing to play with a blue block because of its color even if the child wants to play with blocks. *Health Promotion and Maintenance*
2. (3) Magical thinking is defined as believing that thoughts are all powerful and that they can cause events. A child who thinks they can make it rain is engaging in magical thinking. Preschoolers do not fully understand the cause and effect of events such as if it rains we can't have the picnic. If they were engaging in magical thinking they would believe they could make it stop raining so they could have the picnic. If the child believes God can stop the rain that is not magical thinking. They wouldn't need God to stop the rain if they were engaged in magical thinking. Acknowledging that it won't rain tomorrow is not giving them the power of their thoughts to make it quit today. *Health Promotion and Maintenance*
3. (4) Having imaginary playmates is normal behavior for preschoolers. The imaginary playmates provide the child with diversion, give them a friend when they are lonely, allow the child to succeed in areas not yet successful, and have a friend to blame when things go wrong. It is not purposeful lying to tell about their "friend." Children with imaginary playmates are very social and have many other friends. This isn't created out of a social need but is normal development behavior. A pet may create a diversion but many preschoolers are not suited to having pets and that won't make the "friend" go away. *Health Promotion and Maintenance*
4. (4) By the age of 5 children have fully developed adult speech and are capable of multiple word sentences using all parts of speech. An 18-month-old uses two word sentences, a 24-month-old two-three word sentences, and a three-year-old uses three-four word sentences. *Health Promotion and Maintenance*
5. (4) At 36 weeks gestation the pregnant woman can anticipate her fundus being just below the ensiform cartilage. However, the size of the uterus can be inconsistent with the length of gestation. At 10–12 weeks the fundus can be palpated slightly above the symphysis pubis. At 20–22 weeks the fundus will be at the umbilicus. At 28 weeks the fundus is three finger breadths above the umbilicus. *Health Promotion and Maintenance*
6. (4) Linea nigra is the correct name for a brown line down the abdomen occurring during pregnancy. It usually extends from the umbilicus or above the pubic area. Striae gravidarum are commonly called stretch marks and develop in many women as the abdomen is stretched to accommodate the enlarging uterus. Their appearance is reddish and wavy when new and silver or white the older they are. They appear on the abdomen, thighs, buttocks, and breasts. Applying cream to linea nigra will not cause it to disappear. The nurse would have to ask the ingredients of the cream to know whether or not it contained components that would be harmful to the fetus if absorbed into the blood stream. Melasma gravidarum (cholasma) is commonly called the face mask of pregnancy and usually improves or goes away entirely after the baby is born. *Health Promotion and Maintenance*
7. (4) Melasma gravidarum, also known as cholasma, is a darkening of the skin on the forehead and around the eyes that develops during pregnancy. It is more prominent in dark-haired women and will fade or become less visible soon after childbirth. It is aggravated by sun exposure so avoiding the sun can help prevent progression. Teaching is always a nursing intervention but in this scenario it is better to tell the woman what she can do to minimize or decrease the pigmentation. It is difficult to eliminate the visibility of melasma with make-up, and because of the increased activity of sebaceous glands during pregnancy the use of make-up may exacerbate acne. Melasma will fade after the child is born but that does not address the woman's immediate concern of current visibility. Melasma is a normal finding of pregnancy and explaining this is part of teaching. It doesn't give her something to do to minimize it though and that is her primary concern. *Health Promotion and Maintenance*

8. (2) When a pregnant adolescent begins to experience the body changes associated with pregnancy they may wear restrictive clothing to try and conceal their changing body and/or the pregnancy. This is a behavior consistent with body image disturbance minor defining characteristics such as trying to hide the involved body part. Wearing maternity clothes during the second trimester acknowledges the increased abdominal growth and making the appropriate accommodations. Many pregnant adolescents will try to maintain their prepregnant weight out of a concern for becoming obese or disclosing their pregnancy. It is difficult and sometimes frightening for the pregnant adolescent to see the changes their body goes through and to sort out those changes associated with puberty versus pregnancy. To buy a supportive bra demonstrates the adolescent's recognition that her breasts are enlarging and need support. *Health Promotion and Maintenance*
9. (2) The drainage rate of peritoneal fluid should be slowed in order to decrease hypovolemia with subsequent hypotension. The client may develop shock if the nurse only monitors or documents! *Reduction of Risk Potential*
10. (3) Fecal occult blood testing is done to detect blood in the stool, which may occur with gastrointestinal bleeding, not the other disorders. *Reduction of Risk Potential*
11. (1) The client is given sedation for this test, so he will need someone to drive him home. He cannot eat or drink until the gag reflex returns, which is usually within 1 to 2 hours. If he develops a fever, he needs to report it to the physician immediately, as it may represent possible perforation. *Reduction of Risk Potential*
12. (4) There should be a 20–30 minute period after suctioning before a blood gas is drawn, in order to obtain accurate values. The other options fall below that. *Reduction of Risk Potential*
13. (3) Pressure should be held at the injection site for 5 minutes in a normal client, but 10–15 minutes in a client receiving anticoagulants (such as Heparin) or who has bleeding tendencies. *Reduction of Risk Potential*
14. (2) This statement gives nonjudgmental permission for the client to share their story. The other statements are insensitive, and do not facilitate a therapeutic response. *Reduction of Risk Potential*
15. (4) Palpation is the most appropriate assessment technique the nurse can use to examine the prostate gland. *Physiological Adaptation*
16. (1) Mastitis may develop in the woman who is breast-feeding. The remaining options are not associated with breast-feeding. *Physiological Adaptation*
17. (2) Human papilloma virus is associated with genital warts, not the other conditions. *Physiological Adaptation*
18. (4) Many illnesses present differently in an older adult than in a younger one. Depression in an older adult is characterized by the clinical manifestations listed in options 1, 2, and 3. Depression presents in younger adults with withdrawal, crying, and insomnia. *Health Promotion and Maintenance*
19. (3) Illnesses in older adults present differently than the same illness in a younger adult. The symptoms listed in the question are consistent with the presentation of a urinary tract infection in a senior adult. The distinguishing clinical manifestation in differentiating the cause of the symptoms in the question is incontinence. Because of the aging immune system many elders will not have an elevated temperature even with acute infection. Pneumonia in an older adult presents with a nonproductive or absent cough, and no fever or chills. Congestive heart failure in an older adult has many of the same symptoms as in a younger adult plus confusion, falls, agitation, and anorexia. Myocardial infarction presents in an older adult with atypical pain location, no pain, tachypnea, and confusion. *Health Promotion and Maintenance*
20. (1) While all of the interventions listed will assist the client to cope with the musculoskeletal changes of aging, maintaining adequate calcium intake is the priority intervention. Loss of calcium from the bone is the major age-related change in the skeletal system. This causes gradual decreases in height, slower synthesis of bone, decreased calcification, and eventual osteoporosis. Ensuring that the elder is getting adequate calcium can prevent these age associated losses. Placing commonly used items within easy reach and/or providing assistive devices to extend the reach are both appropriate nursing interventions that can help the elder to be self-reliant and avoid injury. As aging occurs, the elasticity of muscle decreases, they become less flexible, and stiffness follows. If the elder exercises as tolerated every day they can compensate or prolong the onset of these age related changes. *Health Promotion and Maintenance*

- 21. (3)** Weakening of the pelvic diaphragm is an expected outcome of aging. Because of this, bladder tone and proper closure of the bladder outlet is impaired. Pelvic muscle exercises can strengthen tone and closure, thus preventing or assisting in managing urinary incontinence. P.O. fluids should be adequate but regulated in amount and timing to avoid overfilling the bladder. Diuretics should be administered in the morning time to allow for urination and the recognition of the sensation to void when the elder is fully awake and more mobile. Perineal care can be compromised in the elderly because of limited mobility and other self-care issues. They may not have frank bowel incontinence but there can be staining on the underwear which can sufficiently contaminate the urethra. More frequent perineal hygiene is indicated in the elderly. *Health Promotion and Maintenance*
- 22. (4)** Women who are already obese should be counseled to gain 15 or fewer pounds during their pregnancy. More importantly, though, is that her diet is per the food pyramid. Women who are underweight before becoming pregnant should gain 28–40 pounds during their pregnancy. Women who are of normal weight should gain 25–35 pounds, and women who are overweight but not obese should gain 15–25 pounds. *Health Promotion and Maintenance*
- 23. (2)** An anthropoid pelvis is not favorable for vaginal birth and a C-Section should be anticipated. The administration of oxytocin augments labor and facilitates vaginal birth. It would not be appropriate in this instance since a vaginal birth is unlikely. A precipitous labor is a vaginal birth occurring within 3 hours of the onset of labor. Since a vaginal birth is not likely in this instance, the nurse should not anticipate this type of labor. *Health Promotion and Maintenance*
- 24. (1)** In a transverse lie the shoulder is the most common presenting part. The back, abdomen, or an arm may also present in a transverse lie. If the occiput were to deliver first, the fetus would be considered to be in the most common presentation, vertex. A frank breech is when the buttocks are the presenting part. In a brow presentation the sinciput is the presenting fetal part. *Health Promotion and Maintenance*
- 25. (4)** Differentiating between true and false labor can be difficult. Contractions in false labor are relieved by ambulation, changes in position, or a hot shower. The only valid way to differentiate is to have a vaginal exam to see if cervical dilatation and effacement is occurring. Many women experience a burst of energy, not fatigue during the 24–48 hours preceding the onset of labor. Once a bloody show has begun, labor generally ensues within 24–48 hours. About 80 percent of women whose membranes rupture before the onset of labor will start having contractions within 24 hours. If labor does not begin within 12–24 hours the woman may need to have it induced to avoid infection. *Health Promotion and Maintenance*
- 26. (1)** The client should be able to bear weight on the affected extremity in order to use a cane. The client should advance the cane with the affected extremity with the person on the client's affected side. *Basic Care and Comfort*
- 27. (4)** The most important nursing observation is evidence of skin breakdown, particularly where the body and brace will be in contact. Any skin breakdown can lead to very difficult consequences as infection and can delay the rehabilitative process. Back deformities, weakened muscles, and cardiac output should be observed and could have some importance in the outcome, but are not the primary observations when braces are used. *Basic Care and Comfort*
- 28. (1)** The physician orders the setting for Flexion, Extension, and Speed; these are generally increased gradually as tolerated to maximum mobility. These devices are most commonly used for passive range of motion for the knee. *Basic Care and Comfort*
- 29. (1)** Aseptic technique is sterile technique used to prevent/decrease risk of infection when inserting a urinary catheter. Aseptic technique begins with the manner in which the box is opened. *Basic Care and Comfort*
- 30. (4)** Flowing saline will keep the urine flow steady so that blood will not be static long enough to form clots. *Basic Care and Comfort*
- 31. (3)** Catheter taping on the lower abdomen prevents downward pressure of the catheter causing a scrotal sac abscess or erosive ulcer. *Basic Care and Comfort*
- 32. (2)** The most common type of contractures seen are flexion contractures. Flexion tendons are stronger than extension tendons so the normal position naturally assumed is flexion. *Basic Care and Comfort*
- 33. (1)** "Foot drop" is also known as plantar flexion. The sole of the forefoot is flexing towards the heel. "Foot drop" is best prevented using high top tennis shoes to hold the foot in correct alignment and support. *Basic Care and Comfort*

- 34. (4)** DVT is a problem of immobility secondary to slowed blood flow, lack of laminar flow in vessels, and cellular elements damaging and attaching to the vein wall. DVT can be prevented or decreased by teaching patient to do “ankle pumps” or pulling his/her toes toward his/her nose 15 times in 30 minutes. *Basic Care and Comfort*
- 35. (2)** Ecchymosis is a collection of blood in the subcutaneous tissues (dermis) causing purplish discoloration. The other responses would not be classified as a “bruise.” Sebaceous glands secrete an oil that lubricates the skin; a sebaceous cyst is an infection of the sebaceous gland; epidermal abrasion is a trauma area of the outer layer of the skin. *Basic Care and Comfort*
- 36. (3)** Culture may influence personal hygiene as the bath. *Basic Care and Comfort*
- 37. (1)** Older skin due to natural aging may be dryer and thinner and more easily injured; itching can be normal or an introduction to infection. *Basic Care and Comfort*
- 38. (3)** The diaphragm should be left in place for 6 hours after intercourse. If intercourse takes place again within 6 hours, additional spermicide must be used with the aid of an applicator. The diaphragm should not be disturbed. The diaphragm should be used with a spermicide. The client places about 1 teaspoon of spermicide around the rim and in the middle of the diaphragm before insertion. If the diaphragm has been inserted more than 4 hours prior to intercourse, additional spermicide should be inserted. If inserted correctly there should be no discomfort with the use of a diaphragm. *Health Promotion and Maintenance*
- 39. (2)** The diaphragm must be fitted by a trained professional. The size must be rechecked after the birth of a child and with a weight gain or loss of 15 pounds. Since the client in the question has been using her diaphragm for 2 years and has recently experienced the birth of a child, she will need to have the fit rechecked at this visit. Option 1 is wrong because the weight loss experienced is 10 pounds, not 15 or more. Checking for correct placement with each use is recommended. However this is not as critical as option 2. An experienced diaphragm user should have the insertion process down and can supplement with occasional placement checks. The final step of inserting a diaphragm is getting the edge under the symphysis pubis. Some women report a popping sensation when this occurs. Option 4 is a normal finding and not a cause for concern. *Health Promotion and Maintenance*
- 40. (4)** The newer or current generation of IUDs (intrauterine devices) are thought to truly be contraceptive and inhibit or alter sperm migration and alter or inhibit ovum migration. They do not prevent ovulation. Oral contraceptives prevent ovulation. The exact mechanism of action even for the original IUDs was not clearly understood but it was thought that one way they acted was to prevent implantation of the impregnated ovum. That is not how current IUDs are thought to work. IUDs may alter or inhibit ovum migration, not promote it. *Health Promotion and Maintenance*
- 41. (4)** Fever, chills, and malaise are signs of infection and should be reported to the physician immediately. For the first 2–6 weeks after the insertion of an IUD a woman may experience intermittent bleeding and cramping. Being able to feel the string from the IUD through the cervix is a sign the IUD is still in place and is an expected finding. *Health Promotion and Maintenance*
- 42. (1)** Females have a shorter urethra, and diabetes compromises the immune system. The other options do not have such risk factors. *Reduction of Risk Potential*
- 43. (3)** E. coli most commonly (80 percent) causes urinary tract infections in clients without structural abnormalities or calculi, not the other bacteria. *Reduction of Risk Potential*
- 44. (4)** Bubble baths can irritate the urinary tract, causing predisposition to a UTI. Antibiotics need to be taken until the prescription is finished. Fluids need to be increased. Females need to wipe front to back after urinating. *Reduction of Risk Potential*
- 45. (2)** Nephrotoxic drugs can affect renal function. Therefore, it is imperative to follow the amount of fluid entering and leaving the patient. ALT and AST levels measure liver function. Balance is a function of the cochlear apparatus in the inner ear. Cognitive function is a high brain function. *Pharmacological Therapies*
- 46. (1)** Moderately high therapeutic doses of aspirin can cause tinnitus, the perceived sensation of sound in the absence of acoustic stimulation. The noise may be described as a “ringing in the ear” or a hissing, roaring, humming, whistling, chirping, or clicking. Tinnitus is not reported with use of these medications. *Pharmacological Therapies*

- 47. (2)** Acetaminophen is extensively metabolized by pathways in the liver. Toxic doses of acetaminophen deplete hepatic glutathione, resulting in accumulation of the intermediate agent, quinone, which leads to hepatic necrosis. Prolonged use of acetaminophen may result in an increased risk of renal dysfunction but a single overdose does not precipitate life threatening problems in the respiratory system, renal system, or adrenal glands. *Pharmacological Therapies*
- 48. (2)** Topical agents produce a localized, rather than systemic effect. When treating atopic dermatitis with a steroidal preparation the site is vulnerable to invasion by organisms. Viruses, such as herpes simplex or varicella-zoster, present a risk of disseminated infection. Educate the patient using topical corticosteroids to avoid crowds or people known to have infections and to report even minor signs of an infection. Topical corticosteroid usage results in little danger of concurrent infection with these agents. *Pharmacological Therapies*
- 49. (3)** Typically, first generation OTC antihistamines have a sedating effect because of passage into the CNS. However, in some individuals, especially infants and children, paradoxical CNS stimulation occurs and is manifested by excitement, euphoria, restlessness, and confusion. For this reason, use of first generation OTC antihistamines has declined and second generation product usage has increased. Reye's syndrome is a systemic response to a virus. First generation OTC antihistamines do not exhibit a cholinergic effect. Nausea and diarrhea are uncommon when first generation OTC antihistamines are taken. *Pharmacological Therapies*
- 50. (2)** Using the PQRST technique, stabbing would describe the quality Q of pain the client is experiencing. (S) Severity; (T) Timing of pain; chronic – the type of pain. *Basic Care and Comfort*
- 51. (2)** Relaxation exercises such as guided imagery enhance other pain relief measures to promote comfort of the client. *Basic Care and Comfort*
- 52. (4)** Elderly clients may have decreased perception of sensory stimuli and higher pain threshold. *Basic Care and Comfort*
- 53. (2)** Fluid intake will go for the most part into the extravascular compartments and not be released through the normal output process. *Basic Care and Comfort*
- 54. (3)** Vitamin C, that is, lemons, oranges, fruits, was discovered to prevent scurvy. Vitamin A prevents night-blindness. Vitamin B prevents irritability, Beriberi. Vitamin D prevents Rickets. *Basic Care and Comfort*
- 55. (1)** The best source of Vitamin C to benefit a client with scurvy are fresh fruits, especially citrus (antioxidation). Fats, oils, sugar, bread, cereal, rice, and pasta are not an important source of Vitamin C. *Basic Care and Comfort*
- 56. (4)** Debulking of a tumor is done to decrease the symptoms of the disease or is known as palliative surgery. It does not effect a cure. *Basic Care and Comfort*
- 57. (1)** Medication for cancer patients involves opioid use. Addiction of the patient is not a concern. This form of care is pain control and comfort. NSAMS may be added as an adjunct to opioid medications. *Basic Care and Comfort*
- 58. (4)** Mammography is suggested for every female over age 50 or greater as a primary preventative measure. *Basic Care and Comfort*
- 59. (4)** The Cincinnati Stroke Scale can be performed by EMTs at the scene; options 1, 2, and 3 are more in-depth assessments that may be done later. *Physiological Adaptation*
- 60. (2)** The primary problem in myasthenia is a lack of acetylcholine at the myoneural junction (thought to be autoimmune). Tensilon is a rapid acting acetylcholinesterase inhibitor used for diagnosis and to differentiate cholinergic crisis from myasthenic crisis. If symptoms improve after injection = myasthenia, if they stay the same or worsen, not; options 3 and 4 are acetylcholinesterase inhibitors used to chronically treat myasthenia; option 1 atropine is used to treat cholinergic crisis caused by too much acetylcholinesterase inhibitor. *Physiological Adaptation*
- 61. (2)** Sumatriptan is used to stop a migraine; option 1 is for pain relief, not prevention; option 3 is to treat the nausea associated with migraine; option 4 is a preventative and should be taken every day. *Physiological Adaptation*

- 62. (2)** The patient will have diaphragmatic breathing, but no intercostal muscle movement, important in coughing. The phrenic nerve exits the spinal cord at C4-C5 and shouldn't be damaged by a C6-C7 fracture. The patient may need temporary ventilation during the period of acute swelling. Option 3 is contraindicated as this will push the abdominal contents against the diaphragm, making breathing difficult. The patient in option 4 should be able to cough with assistance and should not require suctioning. *Physiological Adaptation*
- 63. (4)** Batterers cannot be predicted by any demographic feature related to age, ethnicity, race, religious denomination, education, socioeconomic status or class. 95 percent of domestic abuse cases are male perpetrators and female victims. Same-sex partners may also be abused as well as females abusing male partners. *Psychosocial Integrity*
- 64. (3)** Many batterers report having been abused as children. Children who witness domestic violence are more likely to become a perpetrator or victim as adults, than children who were victims of domestic violence. *Psychosocial Integrity*
- 65. (4)** Tricyclic antidepressants take 7–10 days for the therapeutic effect to be noticed. They do not cause euphoria or jitteriness. *Psychosocial Integrity*
- 66. (2)** Exercise has been shown to improve depression. Although coffee is a stimulant, it has not been effective in improving depression. Clients with depression often feel sleepy, but getting more sleep is not an effective treatment for depression. Exercise is beneficial in all stages of depression, but may need to be augmented with medication. *Psychosocial Integrity*
- 67. (2)** Attitudes about childrearing have strong cultural influences. There are no specific standards about childrearing. Although poverty may mimic some of the signs of neglect, there is no direct relationship. Physical injuries are easier to detect than emotional injuries. *Psychosocial Integrity*
- 68. (1)** Delay in seeking medical treatment and inconsistent or extremely detailed history of how the injury occurred are “red flags” to indicate possible child abuse. Other factors include adolescent pregnancy, a history of family violence, and seeing many different healthcare providers. *Psychosocial Integrity*
- 69. (4)** As men age more time and more direct stimulation is needed to achieve an erection. The time of the refractory period is increased, there is a decreased physical need to ejaculate, and the amount of the semen is reduced. Erections tend to be less firm and ejaculations become less intense. *Health Promotion and Maintenance*
- 70. (2)** Many of the chronic illnesses experienced by elderly clients impact their sexual functioning in several ways: physiological process related to the illness, medications taken for the illness and psychological issues surrounding the illness. The nurse should not assume the sexual dysfunction is related to the aging process and seek more information. Option 2 is further assessment and will tell the nurse if the sexual dysfunction could possibly be related to the medication. Many medications taken for diseases interfere with sexual functioning. Aging male clients may require more time and more direct stimulation to attain an erection but normal aging should not prevent them from having an erection. Illnesses that affect mobility, endurance, blood or nerve supply can alter sexual functioning. Option 4 puts the client off and would suggest it isn't appropriate for them to talk about this with the nurse. It is well within the nurse's scope of practice to assess sexual functioning. *Health Promotion and Maintenance*
- 71. (4)** Older adults in a nursing home setting find it very difficult to express their sexuality. Many nursing homes restrict activity, limit physical contact between residents, and restrict sexual expression. By recognizing the sexual needs of elder clients nurses can help nursing home residents with their sexual expression. They should allow socialization with sexual partners, encourage discussion of sexual concerns, and allow clients to close doors to ensure privacy. *Health Promotion and Maintenance*
- 72. (3)** Persons with arthritis experience limited range of motion and may experience pain when trying to position themselves for intercourse. COPD clients may experience dyspnea when having intercourse. Clients who have had a stroke may have damage to the nerve pathways that lead to erectile dysfunction. Diabetic clients may be impotent. *Health Promotion and Maintenance*
- 73. (3)** The use of fantasy can be a normal coping mechanism used to enhance sexual experiences. Fantasies often create a way to increase sexual pleasure without indicating dissatisfaction with a current partner. Fantasy becomes maladaptive when it is used for a replacement of actual sexual expression. Projection is a coping mechanism that blames the partner for sexual dysfunction. Rationalization is another common coping mechanism related to

sexual health but is maladaptive in nature. It allows the person to avoid dealing with sexual issues and attempt to rationalize or explain why there is a difficulty with sexual functioning. When clients use denial as a coping mechanism for sexual dysfunction it is characterized by a refusal to admit there is a sexual problem and is considered maladaptive. *Health Promotion and Maintenance*

- 74. (4)** When a family member has low self differentiation they are emotionally reactive when stressed. They are less adaptable, less flexible, and more emotionally dependent on those around them. Those family members having a high degree of self differentiation have all of the characteristics listed in options 1, 2, and 3. In times of stress they are able to engage in intellectual thinking, are more flexible, more adaptive, and are not as affected by the emotions of those around them. *Psychosocial Integrity*
- 75. (2)** Triangles are not a bad thing. They are the basis for emotional systems. A triangle consists of three people, two people and a group, two people and an object, or two people and an issue. It is a myth that one member of the triangle is a victim. By playing a victim role the person eliminates their responsibility. The truth is that all members of a triangle participate equally in maintaining the triangle. It cannot exist without the active cooperation of all of its members. The person's position in the triangle can change depending on the issue. *Psychosocial Integrity*
- 76. (1)** When working with a family the nurse can recognize when he/she has stopped being therapeutic and has become a member of the triangle by objectively monitoring their own behavior. The following behaviors indicate the nurse has become part of the triangle: feeling sorry for or pitying a member of the triangle, feeling angry at a member or how the triangle functions, being overly positive about how the triangle functions, wanting to correct the behaviors of the triangle members, and discovering that the nurse no longer has responses to or questions of the triangle members when they meet together. The nurse remains therapeutic when he/she is able to maintain emotional contact with each family member. Taking sides usually stops any progress being made in therapy, but when a planned strategy it can be helpful to realign with specific family members. To be therapeutic the nurse must be willing to examine his/her own family of origin and recognize the triangles that exist in it. If the nurse does not do this they may take on the same roles/positions within the family they are trying to help. *Psychosocial Integrity*
- 77. (2)** The nurse must avoid becoming part of the family triangle. To get out of his/her own emotional response the nurse should elicit the other family member's responses as in option 2. This feeds the process back into the system and keeps it between the spouses. Option 1 is a true statement but brings the nurse's emotional response into the situation, making him/her part of the triangle. Option 3 delays working through the situation and represents missed opportunity. It does not teach the other member of the triangle how to respond. Option 4 is very judgmental and indicates that the nurse has taken the side of the wife. This is not therapeutic. *Psychosocial Integrity*
- 78. (1)** Purulent drainage is the only one of the signs that indicates a complication of infection in a client with an open fracture. The remaining options indicate different types of complications. *Reduction of Risk Potential*
- 79. (2)** Chest pain is indicative of a fat embolism, as is tachypnea, cyanosis, tachycardia, anxiety, and decreased oxygen saturation. The remaining options are signs and symptoms of neurovascular impairment after a fracture repair. *Reduction of Risk Potential*
- 80. (4)** Bradycardia is not a sign of fat embolism, but rather, tachycardia is such a sign. The remaining options listed are all signs or symptoms of a fat embolism. *Reduction of Risk Potential*
- 81. (3)** Denial is an unconscious blocking out of threatening or painful information or feelings. Regression involves using behaviors appropriate at an earlier stage of psychosexual development. Displacement shifts feelings to a more neutral person or object. Projection attributes one's own unacceptable thoughts or feelings to another. *Psychosocial Integrity*
- 82. (2)** Moderate anxiety causes the individual to grasp less information and reduces problem-solving ability to less than optimum level. Mild anxiety heightens attention and enhances problem-solving. Severe anxiety causes great reduction of the perceptual field while panic level anxiety results in disorganized behavior. *Psychosocial Integrity*
- 83. (2)** The person's self-concept includes: body image, identity, roles, self-esteem, self-ideals. *Psychosocial Integrity*
- 84. (1)** In primary prevention, the psychiatric nursing functions include: Health Education, Referral, Support of family, work in the community. *Psychosocial Integrity*



- 85. (2)** Rational-emotive therapy addresses myths and misconceptions persons hold that influence behavior. Behaviors such as standing up for one's beliefs, believing that one can change despite past experiences or behaviors, and that each person is worthy of love and acceptance irrespective of status or attributes are values linked with mental health. *Psychosocial Integrity*
- 86. (1)** Substance related disorders pose key medico-legal and ethical-moral considerations. The nurse should first assess the patient fully to ascertain an undisclosed physical, mental, or spiritual cause mistaken as an alcohol or other substance disorder. During the assessment, the nurse must be cognizant of defense mechanisms that substance users employ and be ready to confront excuses for behavior with facts and findings that are appropriate. All atypical behaviors should be discussed not simply absences as patients will often have ready excuses. Employers must arm employee health nurses with the policies and protective procedures necessary to allow drug testing when needed which is typically done after assessment and confrontation. *Psychosocial Integrity*
- 87. (1)** IV tubing should be replaced every 24 hours in the client receiving total parenteral nutrition. This is because such solution is highly concentrated, and can foster the growth of bacteria, which may cause an infection. The remaining times are too lengthy, and would predispose the client to a risk of infection. *Reduction of Risk Potential*
- 88. (2)** When a central venous pressure reading is taken, the nurse should align the manometer with the right atrium of the heart. This is so an accurate pressure reading will be obtained. The other options will not give an accurate pressure reading. *Reduction of Risk Potential*
- 89. (3)** The nurse should first notify the physician of redness and yellow drainage at the site, as these are indicators of infection. The physician will likely order the line to be removed, and antibiotics to be administered. The line cannot be removed without a physician's order. *Reduction of Risk Potential*
- 90. (2)** Group sharing of lifestories is probably the most effective measure the nurse could employ to achieve sustained positive effects as the intervention encourages cognitive processing. The sharing of others helps to stimulate and remind others of what events mean such as Christmas and birthdays. Reading and exercise would be of some but limited value to the individual not the group as calling the client by a first name or nickname. Some authorities cite that addressing the client in a juvenile manner encourages regression. *Psychosocial Integrity*
- 91. (3)** In systematic desensitization the client imagines the anxiety-producing situation or deals with the real-life situation at a gradual pace until anxiety is virtually diminished. Identifying anxiety producing experiences is necessary, but alone this will not manage the anxiety. Having the client experience large crowds will not help manage the anxiety, nor will aversion therapy. *Psychosocial Integrity*
- 92. (1)** Nurses are mandated to report suspicions of child sexual abuse and are protected from prosecution, unless the nurse knew the report was false. *Psychosocial Integrity*
- 93. (4)** Sexual abuse may involve contact or non-contact. Non-contact forms of child sexual abuse include exhibitionism, inappropriate observation of child, the production or viewing of pornography, or involvement of children in prostitution. *Psychosocial Integrity*
- 94. (2)** An increase in fiber helps to increase the motility of the GI tract. This can help the elderly population with the tendency toward constipation. Increasing Vitamin E and taking an aspirin once a day do not have a direct effect on the motility of the GI tract. Decreasing water intake can worsen the existing problem. Increasing water intake can help in preventing constipation. *Health Promotion and Maintenance*
- 95. (1)** Incentive Spirometry is an important intervention in the prevention of pneumonia postoperatively. This activity increases lung capacity and helps mobilize the secretions that may have settled in the client's lungs during and after surgery. Eating soft food after surgery maybe ordered once the client has progressed from clear to full liquids. This diet will not intervene in the development of pneumonia postoperatively. Supplemental oxygen may be ordered but would not decrease the risk of developing pneumonia from the settling of secretions. Splinting the abdomen will help the client prevent pain when coughing or turning but is not an effective intervention in the prevention of pneumonia. *Health Promotion and Maintenance*
- 96. (4)** The statement from the client indicates she understands the importance of activities associated with disease prevention. There is no indication that she is at high risk for either breast cancer or heart disease. She did not indicate that she would participate in health promotion activities such as adhering to a heart healthy diet or participating in aerobic exercise classes 3–5 times a week. *Health Promotion and Maintenance*

97. (1) The nurse should document all data specifically and completely, including normal and abnormal findings. Proper documentation is essential for organizing complete or partial assessment data. To document the physical assessment, the nurse should organize and record all findings by body systems. *Health Promotion and Maintenance*
98. (1) No matter what the client's condition, a partial assessment should include a general survey, vital sign measurements, and evaluation of certain body structures and systems. The partial assessment focuses on a specific client concern or problem. It may be performed in many different healthcare settings. The partial physical assessment evaluates a specific symptom(s) or problems report in the health history. *Health Promotion and Maintenance*
99. (1) The bell portion of the stethoscope is used to auscultate for low-pitched murmurs and gallops. Heart sound assessment should identify the pitch, intensity, duration, timing in the cardiac cycle, quality, location, and radiation of any sound. The nurse should accurately auscultate the heart. *Health Promotion and Maintenance*
100. (1) is correct. Choice 2 is incorrect because advance directives are not irrevocable. Choice 3 is incorrect as these documents have differing frames and formats in differing states. Choice 4 is incorrect. These documents are legally binding if executed according to state guidelines which do not include court action. *Coordinated Care*
101. (2) In instances of suspected child abuse, the nurse advocate has a responsibility to the patient to convey the concern verbally to the physician, in writing through complete factual documentation, and by following the facility's protocol for processing of such a suspicion. *Coordinated Care*
102. (3) The steps in Case Management are assessment, planning, implementation, coordination, monitoring, and evaluation. *Coordinated Care*
103. (3) Lead poisoning (plumbism) is responsible for chronic illness and mental retardation in some children. The exposure to lead typically occurs via the ingestion of lead based paint chips or plaster constructed prior to the 1970s. *Safety and Infection Control*
104. (3) Measuring the drug blood level is essential when a client is taking Lithium since it has a narrow therapeutic index and can become subtherapeutic or toxic quickly. Patients on Lithium experience polyuria as a side effect of the drug and need careful monitoring for signs of dehydration. Certainly, the specific gravity of urine is one lab measure of hydration, but most importantly is assuring the drug is in its therapeutic range correlated with the assessment of clinical signs of hydration. *Safety and Infection Control*
105. (4) Syphilis, GC, Chlamydia, Hepatitis, Rubella, red blood count and ABO screening should be done at the initial prenatal visit. *Safety and Infection Control*
106. (1) High fat content foods enhance the absorption of the anti-fungal, Griseofulvin. *Safety and Infection Control*
107. (2) The "Patient's Bill of Rights" describes the right of the patient to refuse to participate in research without the fear of loss of care by the healthcare team. He will still be cared for by physicians and nurses on the team, and other treatment options may be offered. The costs of research are commonly at least partially paid by the research study. *Coordinated Care*
108. (2) Networking involves the process of developing and using contacts throughout one's professional career for information, advice, and support. Nurturing and mentoring are both examples of assistance to other colleagues in formal and informal relationships for support and career building. Collegiality is the professional camaraderie or rapport established among persons through shared experiences. *Coordinated Care*
109. (4) Computer access to confidential records should be guarded for the privacy of the patient. Unauthorized access to information by those not requiring access or by visitors/non-employees in a healthcare institution is considered a breach of privacy and confidentiality. *Coordinated Care*
110. (1) A neurologist would evaluate this patient for a possible CVA. A gastroenterologist works with patients with digestive problems, a physiatrist works with patients with rehabilitation needs, and a pulmonologist would work with patients with respiratory problems. *Coordinated Care*
111. (4) A healthy diet and exercise are two of the most common and basic primary prevention health strategies; i.e. they work to keep healthy people healthy. Water aerobics to control symptoms and strengthen the musculoskeletal system is a secondary prevention tactic. Cardiac rehab and physical therapy following a hip fracture are both considered tertiary as they help patients deal with losses. *Safety and Infection Control*

- 112. (3)** A soap and water scrub is more prudent after a dressing change since blood may be present even if not visible. Alcohol based hand gels do not have bacteriocidal properties. A thorough handwashing with soap and scrubbing is the best course of protection after a dirty wound change. *Safety and Infection Control*
- 113. (4)** Metronidazole, an anti-fungal is the drug of choice for sexually transmitted trichomoniasis. *Safety and Infection Control*
- 114. (4)** One condition of restraints is that they are periodically removed. Because restraints restrict a client's basic freedom to move, careful assessment and accurate, complete documentation are essential. The client needs to have range of motion and movement of body. *Safety and Infection Control*
- 115. (4)** Nursing Diagnosis related to falls and confusion are based upon the concept that falls can break bones and self-confidence, leading to fear of falling, causing a decreased activity level and decreased muscle strength. All increase the risk of falling. *Safety and Infection Control*
- 116. (3)** Hyperosmolar fluids has more particles than water; hyperosmolar fluid, which has more particles than water. The plasma/serum osmolality (concentration of circulating body fluids) can be calculated if the serum sodium level is known or the sodium, glucose, and blood urea nitrogen (BUN) levels are known. Sodium is the main extracellular electrolyte and its major function is to regulate body fluids. *Physiological Adaptation*
- 117. (1)** Hypo-osmolar fluid has fewer particles than water. The concentration of body fluid is described as osmolality and osmolarity; these terms are frequently used interchangeably. Osmolality is the osmotic pull exerted by all particles (solutes) per unit of water, expressed as osmoles or milliosmoles per kilogram (mOsm/kg) of water. *Physiological Adaptation*
- 118. (3)** Crystalloids do not interfere with type and cross-match of blood. They raise the blood pressure rapidly; however, the blood pressure will remain elevated longer with colloids than with crystalloids; colloids provide protein and fluid for the body and prevent shock and promote wound healing; crystalloid is helpful in establishing renal function. It restores extracellular blood volume and replaces sodium chloride deficit. *Physiological Adaptation*
- 119. (2)** Hyponatremia, hypomagnesemia, and hypocalcemia all may result in neuromuscular irritability with seizure activity. Hypokalemia commonly produces dysrhythmias, weakness, and anorexia but is not associated with seizure activity. *Physiological Adaptation*
- 120. (1)** Petechiae are characteristic of quantitative or qualitative platelet defects since platelets are primarily responsible for cessation of bleeding in small vessels; thrombocytopenia—a quantitative platelet disorder; the most common cause of bleeding into muscles and joints with even minor trauma; purpura refers to extravasation of blood into skin and mucous membranes; platelet defects produce: Petechiae, easy bruising, bleeding; as condition worsens, other systems are affected. *Physiological Adaptation*
- 121. (3)** Fresh frozen plasma contains all the coagulation factors, including the labile factors (V and VIII); plasma the liquid portion of whole blood constitutes 55 percent of blood volume and contains large quantities of organic and inorganic substances. Platelets help to control bleeding—activate biochemical substances that activate coagulation factors in plasma to form a stable fibrin clot; coagulation of fibrin clot formation results from a complex series of reaction wherein inert plasma proteins are “activated” or transformed into enzymes in sequential manner, ending with thrombin-induced conversion of fibrinogen to fibrin (cascade theory). *Physiological Adaptation*
- 122. (3)** Vitamin B<sub>12</sub> is essential for nervous system function, and the neurologic manifestations of B<sub>12</sub> deficiency are not seen in folic acid deficiency; anemia—a clinical condition (not a laboratory result) defined as decrease in hemoglobin content or red cell mass that impairs oxygen transport; management is directed toward the cause of anemia and replacing blood loss as needed to sustain adequate oxygenation. Nurse-educate client as to nutrition and nutrition supplements (iron, Vitamin B<sub>12</sub>, folic acid, ascorbic acid); rest, exercise, adequate nutrition, support. *Physiological Adaptation*

- 123. (4)** This client is at risk of spontaneous bleeding. Preventing constipation decreases the risk of intracerebral bleeding secondary to increased intracranial pressure with Valsalva maneuver; this maneuver is done for the increased risk of cerebral bleed; symptomatically treat cough, constipation, chills, nausea, and vomiting. Nurses educate the client to avoid alcohol, aspirin, other substances that interfere with platelet function; rest, emotional support, primary prevention—accidents, falls, counseling if needed. *Physiological Adaptation*
- 124. (2)** Passive Immunity—immunization by a transfer of specific antibody from an immunized person to one who is not immunized; a form of acquired immunity from artificial by injection of antiserum for treatment or prophylaxis; it is not permanent and does not last as long as active immunity; option 1: acquired immunity that protects the body against a new infection, as the result of antibodies that develop naturally after an initial infection or artificially after a vaccination; option 3: Natural Immunity—a usually innate and permanent form of immunity to a specific disease; option 4: Horizontal transmission—the spread of an infectious agent from one person or group to another, usually through contact with contaminated material, such as sputum or feces. *Physiological Adaptation*
- 125. (3)** Endemic (of a disease or microorganism) indigenous to a geographic area or population; option 1: Epidemic—affecting a significantly large number of people at the same time; a widespread disease that tends to occur periodically. Option 2: Pandemic (of a disease) occurring throughout the population of a country, a people, or the world; option 4: Herd Immunity—immunity of a group or community. *Physiological Adaptation*
- 126. (2)** Epidemic—affecting a significantly large number of people at the same time. *Physiological Adaptation*
- 127. (2)** Nitroglycerin is administered to the patient with chest pain because it dilates the blood vessels and decreases the work of the heart. A drop in the blood pressure is a side effect of nitroglycerin. This medication should not be administered to unconscious patients. *Physiological Adaptation*
- 128. (4)** The majority of cardiovascular emergencies are not a result of complications of cardiovascular surgery. Instead, they are a result of changes in the inner walls of arteries, or problems with the heart's electrical and mechanical functions. *Physiological Adaptation*
- 129. (1)** The reason an emergency occurs in most cardiac-related medical emergencies is due to reduced blood flow to the myocardium. This may, in turn, cause cardiac arrest, loss of consciousness, or breathing difficulty. *Physiological Adaptation*
- 130. (2)** Angina pectoris means, literally, a pain in the chest, a paroxysmal thoracic pain caused most often by myocardial anoxia as a result of atherosclerosis of the coronary arteries. The pain usually radiates down the inner aspect or the left arm and is frequently accompanied by a feeling of suffocation and impending death. Attacks of angina pectoris are often related to exertion, emotional stress, and exposure to intense cold. The pain may be relieved by rest and vasodilatation of the coronary arteries by medication such as nitroglycerin. *Physiological Adaptation*
- 131. (4)** FFP contains numerous clotting factors and is used in the initial treatment of bleeding related to DIC. DIC is eliminated by treating the underlying cause. FFP is not used to treat myelosuppression. Hemophilia A is caused by a lack of clotting factor VIII. Cryoprecipitate is the blood product that contains therapeutic levels of factor VIII. FFP is not an agent to treat infection. *Pharmacological Therapies*
- 132. (3)** To dilute a 25 percent solution to a 5 percent solution the nurse will need a ratio of 1 milliliter of 25 percent solution and 4 milliliters of diluent (1:5). For a final volume of 20 milliliters, the nurse will use 4 milliliters of 25 percent albumin and 16 milliliters of lactated Ringer's solution to maintain the 1:5 ratio. The 25 percent product can be used safely. The physician has ordered this treatment to be given immediately. The nurse can safely and quickly prepare the product. Obtaining the product from the pharmacy will result in an unnecessary delay in patient care. The ratio in option 4 is incorrect (1:1) and will not provide a final 5 percent solution. *Pharmacological Therapies*
- 133. (1)** The port and tubing inserted into the vein are entirely under the skin. Once the surgical incision sites have healed, the patient resumes previous activities including showering and swimming. The nurse can give the patient the information in options 2 and 3. Any dressing, including an occlusive one, is unnecessary once the surgical incisions have healed. *Pharmacological Therapies*

- 134. (2)** This cancer patient can receive his chemotherapy and parenteral nutritional support (hyperalimentation) through a CVAD. A risk of infection is present with all foreign objects. CVADs, especially if tunneled under the skin and scrupulously maintained, have a low infection rate. CVADs are routinely used for chemotherapy administration. The need for venous punctures may be reduced or eliminated but this is not the primary benefit from a CVAD. *Pharmacological Therapies*
- 135. (1)** Ointments are semisolid preparations incorporated into a vehicle base. The base used for ointments is thicker which enables the drug to adhere to the tissue for a sufficient length of time to exert its effect. Creams have a slightly less semisolid base. Sprays and lotions are often formulated as oil-in-water emulsions. The water will evaporate. *Pharmacological Therapies*
- 136. (3)** First generation antihistamines are sedating. By administering the drug at bedtime the patient will sleep, thus preventing the itch-scratch cycle. The patient may or may not have concomitant allergies. Atopic dermatitis is not accompanied by post nasal drip or coughing. *Pharmacological Therapies*
- 137. (4)** RNs administering antineoplastic medications via the IV route must be chemotherapy certified. This credential requires advanced knowledge of chemotherapeutic agents and their administration. It reduces the likelihood of errors. The agents in options 1, 2, and 3 may be given by an RN and require no advanced education or training. *Pharmacological Therapies*
- 138. (1)** Each tenth of a milliliter contains 1 milligram of morphine sulfate. To give the patient 2 milligrams the nurse should administer 0.2 milliliters. 2, 4: These steps are unnecessary. The nurse can calculate and prepare the correct dose. 3: This step delays appropriate pain control for the patient. *Pharmacological Therapies*
- 139. (3)** These vitamins are essential low molecular organic compounds (carbon containing) required in trace amounts for normal growth and metabolic processes. They usually serve as components of coenzyme systems (a non-protein molecule binds with a vitamin to form an active enzyme). Each answer in options 1 and 4 is a partial list. All are necessary. Option 2 are amino acids. *Pharmacological Therapies*
- 140. (4)** These agents supply considerable calories for energy needs. Carbohydrates supply 3.4 kilocalories per gram, while fats supply 9 kilocalories per gram. Amino acids are the building blocks of protein. They are targeted for growth, not energy production. Trace elements supply no energy. Glucose is a carbohydrate that does supply energy. Fat emulsion, such as Intralipid, does supply energy. *Pharmacological Therapies*
- 141. (2)** Hepatic and renal disease will prolong the time needed for metabolism and elimination of the drug thus increasing the duration of action. *Pharmacological Therapies*
- 142. (2)** Cardiac glycosides such as digoxin can induce rate and rhythm changes, especially at toxic levels. The nurse should obtain written parameters for both high and low heart rates for which cardiac glycosides are to be held. The physician must be notified immediately for changes in rate or rhythm. Adequate hydration is optimal in patients. Withholding food and water is unnecessary. Hypokalemia is a serious side effect of digoxin administration. However, a potassium supplement cannot be administered without a physician's order. The dose of supplement is based on serum potassium lab results. A blood glucose check is not indicated. *Pharmacological Therapies*
- 143. (3)** Lack of sleep is reflected by a decrease in cognitive process; thinking and problem solving are slowed. *Basic Care and Comfort*
- 144. (3)** The RAS controls the sleep-wake cycles. *Basic Care and Comfort*
- 145. (3)** Sleep deprivation increases confusion, disorientation, misinterpretation of environmental events such as mistrust. *Basic Care and Comfort*
- 146. (3)** The most common restraints for adults include jacket, belt, mitt or hand, and limb restraints. *Safety and Infection Control*
- 147. (2)** A procedure is a specific type of process indicator. Structure, process, and outcome are the three types of quality indicators. Structure includes the structure or systems for delivering care. Process indicators evaluate the methods in which care is delivered. Outcome indicators evaluate the end result of care delivered. *Coordinated Care*

- 148. (4)** Delegation is not an indiscriminate assignment, giving orders, or passing along the work that one is responsible for. *Coordinated Care*
- 149. (2)** Supervision is providing guidance and direction, therefore influencing the result of an individual's performance on a task. In that sense it is more than telling people what to do (being the boss). In the supervisor role, a nurse may be involved in direct supervision by observation, but that is not always the case. In nursing, supervision occurs at many levels, from the bedside to top administration in an organization. *Coordinated Care*
- 150. (2)** Supervision is providing guidance and support which may be in the form of assisting patient care. This would be helpful in this situation as it would allow the nurse to give the nursing assistants direction and immediate feedback. This approach is optimal in that it would allow the nurse the opportunity to directly assess the newly admitted patient. *Coordinated Care*
- 151. (2)** The support system is a very useful coping resource for clients. A person who offers strength and understanding would be a good choice to accompany the client to therapy. Group therapy is a good choice for the client who has few social supports. *Coordinated Care*
- 152. (3)** A client with no support and either suicidal or homicidal requires hospitalization until the threat of injury and adequate support is achieved. *Coordinated Care*
- 153. (1)** Although physical symptoms are good indicators of abuse, these same physical symptoms may in fact be related to the aging process. The physiological changes associated with aging include osteoporosis, poor balance, musculoskeletal stiffness, and loss of sense of taste and thirst. *Psychosocial Integrity*
- 154. (2)** Financial abuse includes withholding of money, refusing to allow the client to open a bank account, misuse of the elder's property or money, cashing Social Security checks without the knowledge or consent of the individual, or taking money from a bank account without permission from the individual. *Psychosocial Integrity*
- 155. (2)** Although panic disorder is not life-threatening and seldom requires urgent care, people with panic disorders frequently use emergency department services. People with panic disorder are usually treated as outpatients. *Psychosocial Integrity*
- 156. (1)** The pre-interaction phase allows the nurse to assess feelings about working with a specific type of client and review the purpose of the relationship. The assessment, length of time for the relationship, and plan of care are part of the orientation phase. *Psychosocial Integrity*
- 157. (3)** The physician's orders primarily direct the medical care. The nurse's perception of priorities, patient desires and safety are all the basis of nursing diagnoses, which are a key component of the nursing care plan. *Coordinated Care*
- 158. (1)** is correct. The ethical principle of beneficence is to do good for others. Choice 2, 3 and 4 are incorrect. Allowing patient choices, considering consequence of actions, and decision making are steps of the ethical decision making process. *Coordinated Care*
- 159. (3)** In regard to implications for family healthcare, these models (Pender) emphasize the significance of the family's and the family members' belief system. If a family perceives a threat and if avenues are then presented to the family for reducing the threat, such as accessible and effective screening, health services, lifestyle improvements, and education, the family will be more likely to act positively on its behalf. A health practitioner should not use the fear tactic to build up anxiety and readiness without offering an effective and accessible remedial action to handle and reduce the threat. *Health Promotion and Maintenance*
- 160. (2)** Researchers acknowledge that it is not possible for families to become highly responsible about their healthcare function if healthcare professionals are excluded from participating in their management. Such a partnership role is needed whether promotive, preventive, curative, or rehabilitative health needs are under consideration. People must be treated as responsible adults, not passive children if professionals wish them to assume self-responsibilities. *Health Promotion and Maintenance*
- 161. (4)** One reason that families are having difficulties providing healthcare to their members is the lack of access to care. Race and level of income and education contribute to class differences in healthcare service access and utilization. Minority populations and those with lower levels of income and education utilize preventative healthcare services less frequently. The nonwhite populations spend fewer days in the hospital, see a physician

less often, and are more likely to be treated in a hospital outpatient clinic than in a physician's office (United States Department of Health and Human Services U.S. [DHHS]). For such groups, poor experiences with healthcare system are likely to lead to low rates of service utilization for health examinations and treatments. Another major factor explaining differences in access and utilization patterns of medical services is the lack of healthcare insurance coverage. *Health Promotion and Maintenance*

162. (2) A single cup of coffee before bedtime is unlikely to disrupt sleep, but two or more cups increase sleep latency and reduce total sleep time. *Health Promotion and Maintenance*
163. (2) Usually, older people experience sleep latency, more arousals and fragmented sleep, and less deep sleep. By age 70, a person's sleep is not consolidated into one block, but usually includes a daytime nap. *Health Promotion and Maintenance*
164. (3) Health promotion begins with the family. Wellness strategies, to be successful, usually require improvements in the lifestyle of an entire family. Many studies demonstrate the pervasive influence of the family on health. *Health Promotion and Maintenance*
165. (2) It is important the client follow-up with a physician. The assessment of stressors is important but will not change the recommendation that the client follow-up with a physician. *Health Promotion and Maintenance*
166. (2) Poultry, fruits, and vegetables are consistent with a low cholesterol diet. *Health Promotion and Maintenance*
167. (1) Kegel exercises are pelvic muscle exercise which strengthen the muscles of the pelvic floor. *Health Promotion and Maintenance*
168. (1) For clarity, we might use paraphrasing, which means to restate in different (often fewer) words the basic content of a client's message. As a result, the client is made aware that the interviewer is actively involved in the search for understanding. With restating, the nurse mirrors the client's overt and covert messages; thus, this technique may be used to echo feelings as well as content. Reflection is a means of assisting people to better understand their own thoughts and feelings. A technique that enables the nurse to examine important ideas, experiences, or relationships more fully is exploring. *Psychosocial Integrity*
169. (1) A technique that enables the nurse to examine important ideas, experiences, or relationships more fully is called exploring. The nurse can greatly clarify a vague or generic statement made by a client. *Psychosocial Integrity*
170. (4) Acute grief can be a time of exacerbation of a preexisting medical or psychiatric problem. A history of depression, substance abuse, or post-traumatic stress disorder can complicate grief and may need special treatment. *Psychosocial Integrity*
171. (1) Palliative care is a medical specialty that has grown out of the hospice movement and the increasing national awareness of the need for better care for the dying. It focuses on aggressive comfort care when the goal is no longer cure. *Psychosocial Integrity*
172. (2) The foreign body should not be removed or manipulated. It should be immobilized if possible and the eye covered to protect from further injury. A paper cup can be used in place of an eye patch. Patching both eyes is an inappropriate intervention to prevent ocular movement but follows immobilization of the foreign body. Irrigation with water is an intervention for chemical burns to the eyes. Carbonic anhydrase inhibitors are used to decrease intraocular pressure following blunt trauma. *Physiological Adaptation*
173. (4) Conductive hearing loss results from changes that occur in the external or middle ear. Hearing aids, assistive listening devices (i.e., "pocket talkers"), and reconstructive surgeries can improve or correct hearing loss. Exposure to high levels of noise on an intermittent or constant basis damages the hair cells of the Organ of Corti, resulting in sensorineural hearing loss. *Physiological Adaptation*
174. (3) A client complaining that he has "difficulty eating just about anything" may have a fungal infection of the mouth and/or esophagus. A clinical diagnosis of AIDS suggests that the client is at high risk for developing an opportunistic infection. Acquired Immuno-Deficiency Syndrome—the complex of AIDS includes weight loss, diarrhea, enlarged lymph nodes; decline in body mass with vitamin and mineral deficiency; severe infections, malignancies, and therapies coupled with increased nutritional needs contribute to the wasting; extreme nutrition



monitoring as well as fluid hydration; medication monitoring; if on INH for TB—highest risk for deficiencies of vitamins (B<sub>6</sub>). This drug acts as a vitamin antagonist; also B<sub>12</sub> interferes with absorption. *Physiological Adaptation*

- 175. (3)** Cancer cachexia is a syndrome that occurs in clients with cancer (malignancy) that leads to a loss of muscle, fat, and body weight. It is thought to occur due to tumor-induced changes that cause profound effects on metabolism, nutrient losses, and anorexia. A cycle of wasting is established because alterations in nutrient requirements and intake lead to high cell turnover in body organs, affecting the GI tract and bone marrow. Alterations in digestion occur along with decreased immune response; in simple starvation the body adapts to a lower metabolic rate. The metabolic rate can be normal, decreased, or increased; cachexia occurs in the presence of both chemotherapy and radiation; cancer cachexia can be seen in clients who have adequate caloric intake because it is not calorie dependent; cachexia—general ill health and malnutrition, marked by weakness and emaciation, usually associated with serious disease as cancer. *Physiological Adaptation*
- 176. (2)** Megestrol acetate (Megace) is oral progesterone that is used for both male and female clients to boost appetite and promote weight gain. It is important that all clients receive accurate information about prescribed medications and are aware of the indication for the drug, potential side effects, and expected response to treatment. The nurse should respond to the client's concern initially with factual information because the client does not seem to understand the effect of the medication; Megace has an antineoplastic activity due to suppression of gonadotropine (Antiluteinizing effect); the appetite-enhancing properties (mechanism unknown); palliative treatment of advanced endometrial or breast cancer (not used in place of chemotherapy, radiation, or surgery); use for the treatment of anorexia, cachexia, or an unexplained, significant weight loss in clients with a diagnosis of AIDS. *Physiological Adaptation*
- 177. (4)** Elemental zinc taken with food or milk will help correct alterations in taste (dysgeusia); Dygeusia—impairment or perversion of the gustatory sense so that normal tastes are interpreted as being unpleasant or completely different from the characteristic taste of a particular food or chemical compound; associated nutritional problems—clients receiving radiation therapy are at risk to develop mucositis of the oral cavity, xerostomia, nausea and vomiting, diarrhea, dental caries, esophagitis, dysphagia, and anorexia; clients receiving chemotherapy are at risk to develop anorexia, nausea and vomiting, altered elimination pattern (diarrhea or constipation), mucositis, and altered liver function (jaundice) as a consequence of impaired drug clearance; associated weight loss and accompanying malnutrition correlate with impaired immunity and affect response to therapy and survival. *Physiological Adaptation*
- 178. (3)** An incident report provides a permanent record of the occurrence of an incident for potential reference in the future. They are not to be used for staff discipline or as a performance measure. The report does not conclude that malpractice has occurred, nor hide any wrong doing. *Coordinated Care*
- 179. (2)** Informed consent, once given, can be revoked by the client at any time. Answer(s) 1, 3, and 4 are incorrect. They are true requirements of informed consent. *Coordinated Care*
- 180. (2)** Incident reports are required for unusual or non-intended occurrences. Mrs. Brown's fall was accidental and could have possibly caused harm; although the criterion for an "incident" is not obvious. Mr. Jones fatigue is not an out-of-the ordinary incident. Mrs. Smith experienced symptoms of dizziness and blurred vision, but is not considered an "incident." Mr. Jackson's visit to his brother does not fit the definition of an incident as the information is given. *Coordinated Care*
- 181. (1)** Prior to an imminent death when it is known that the person wanted organ donation and the next of kin agrees, the physician should be notified and orders obtained to notify the local organ procurement organization (OPO) for assessment of the person's potential as a donor. If you wait until after death, organ harvesting may not be possible. The nursing supervisor should be notified you are pursuing organ donation, but may be notified after obtaining the order to call the OPO. The OPO representative or the nursing supervisor will obtain release of the body from the coroner if needed. *Coordinated Care*
- 182. (2)** 0.9 percent sodium chloride is considered to be normal saline. Option 1—this is a slightly hyperosmotic fluid. Option 3—this is one-half normal saline. Option 4—this is one-quarter normal saline. *Pharmacological Therapies*



- 183. (3)** Photodecomposition of the solution will render it ineffective. Protection from light prevents photolysis. Leakage will not be prevented by placing the IV fluid in a dark plastic bag. Specific alert and precaution stickers are placed on medications and IV fluids by the pharmacy. Privacy issues related to all patient care aspects are important. *Pharmacological Therapies*
- 184. (3)** The pH range 7.35–7.45 is the number corresponding to homeostasis, a state of body equilibrium or the maintenance of a stable internal environment of the body. Within this range, all systems and hormones work more effectively. The numbers in options 1, 2, and 4 are outside the normal range. *Pharmacological Therapies*
- 185. (4)** Body image disturbance is the only nursing diagnosis listed that includes all of the signs and symptoms listed in the scenario. The limp, loss of joint motion and swelling over the large joints are manifestations of impaired physical mobility. Activity intolerance is a usual diagnosis for children with JRA. In this scenario it is evidenced by the limp, loss of joint motion, and perhaps the swelling over the large joints. The child is probably limping because of pain but without more information that cannot be confirmed. *Nursing Process*
- 186. (3)** Endogenous erythropoietin stimulates erythroid cell differentiation and proliferation and is secreted primarily by the kidney in response to hypoxia. Administration of epoetin alfa stimulates red blood cell production in anemia states. Epoetin alfa does not stimulate the production of these cells. *Pharmacological Therapies*
- 187. (4)** Vaccines are given to stimulate antibody production that will prevent subsequent disease when the person is exposed to the causative agent. Immunity may be long-term but eventually diminishes, making booster shots necessary to continue protection against disease. A tetanus booster is recommended every 10 years. This patient's immunity has probably significantly diminished over the 9-year period. This patient should receive a tetanus booster now. Adults require tetanus boosters. Tetanus can affect all age groups. Adult boosters are recommended every 10 years. *Pharmacological Therapies*
- 188. (1)** Nonverbal behavior may have varied meaning among different cultures; therefore, the nurse must validate meaning. There is insufficient information to determine the need for a translator (option 2). Option 3 is unnecessary, and option 4 is premature because the nurse has insufficient data. *Psychosocial Integrity*
- 189. (2)** Assessment of religious practices that the client would find comforting should be accomplished first in order to assist the client with spiritual distress. Option 1 would be done if indicated as an answer to option 2. Option 3 may or may not be appropriate; there is insufficient data in the stem of the question to support it. Option 4 may be needed if other options are unsuccessful. *Psychosocial Integrity*
- 190. (4)** Culture can be defined as the nonphysical traits, such as values, beliefs, attitudes, and customs, that are shared by a group of people and passed from one generation to the next. Culture defines how health is perceived. *Psychosocial Integrity*
- 191. (4)** The peripheral motor test evaluates motor muscle movement. *Psychosocial Integrity*
- 192. (4)** A crisis is a stressor that the individual perceives as unrealistic. This is inadequate and ineffective in problem solving, the problem is unresolved, thus a crisis. Options 1, 2, and 3 are incomplete descriptors of a stressor. *Psychosocial Integrity*
- 193. (4)** A home destroyed in a fire or major event is a traumatic stress precipitated by an unexpected external stressor which a person has no control over and could feel overwhelmed. *Psychosocial Integrity*
- 194. (2)** Anxiety is transmissible. The client who “tunes in” to the nurse’s anxiety, usually experiences heightening of their own anxiety. *Psychosocial Integrity*
- 195. (1)** Erickson’s stage of development for middle-aged adulthood is generativity versus stagnation. Behaviors indicating lack of progression would be self-centered (option 1) and demonstrate lack of commitment. Successful progression would be demonstrated by creativity and concern for others (options 2, 3, and 4). *Psychosocial Integrity*
- 196. (2)** Following successful surgery for a hip fracture, a common discharge destination is a skilled nursing facility where nursing, PT, and OT can provide intensive rehabilitation. Discharge to home with either OT or nursing alone would not be suitable for the rehabilitation needs of the patient, and discharge without referral for ongoing therapy and skilled nursing care of the surgical site is highly unlikely. *Coordinated Care*

- 197. (2)** Justice is the ethical principle of using limited resources for all persons who need the service, not just those who may be able to pay for the service. Beneficence (duty to help others), autonomy (respect for the individuality and his/her right to self-determination), and nonmaleficence (the avoidance of harm to others) are additional ethical principles. *Coordinated Care*
- 198. (1)** Steroid therapy causes immunosuppression and is a contraindication for all vaccines. *Health Promotion and Maintenance*
- 199. (1)** Vastus lateralis or ventrogluteal are considered the safest sites for administration of vaccines in infants. *Health Promotion and Maintenance*
- 200. (1)** True contraindications include immunosuppression and previous anaphylactic reaction. Fever and redness at the injection site are common reactions. Mild cold symptoms are not a contraindication. *Health Promotion and Maintenance*
- 201. (3)** Nursing interventions to change family behaviors include providing education. *Psychosocial Integrity*
- 202. (4)** Helping family members identify destructive behavior is an advanced nursing skill but is essential to help the family with destructive behaviors. *Psychosocial Integrity*
- 203. (2)** Self-concept at this age range are: fulfilling role expectation, reasonable expectations, satisfying job, develop new goals, giving meaning and purpose to life. Society places emphasis on intactness of body, fitness, energy, sexuality, style, beauty, and sophistication—important to meet role expectations well. *Psychosocial Integrity*
- 204. (4)** Verbal messages, known as the content portion of the communication, may be reinforced, contradicted, or modified by non-verbal behaviors, known as the process of the message. Thus it is vital to observe both content and process and assess for congruence/incongruence. *Psychosocial Integrity*
- 205. (1)** General leads are remarks that clarify that the client is to take the lead, in this case, to talk about recent events leading to his hospitalization. An example of a broad opening is, “Where would you like to begin?” Encouraging description of perception is exemplified by, “What is happening, now?” An example of seeking clarification would be, “I’m not sure I understand.” *Psychosocial Integrity*
- 206. (2)** Erythromycin is a macrolide antibiotic that causes down-regulation of the cytochrome-450 system in the liver, thus reducing theophylline clearance resulting in an increased theophylline plasma concentration. Options 1, 3, and 4 do not decrease theophylline metabolism. *Pharmacological Therapies*
- 207. (1)** Concurrent administration of iron products and oral antacids will result in significant reduction in iron absorption. 2: Ferrous sulfate can cause GI distress including constipation, gastric irritation, nausea, and abdominal cramps. To minimize these effects the drug can be administered as a coated tablet. *Pharmacological Therapies*
- 208. (1)** TCAs block the uptake of serotonin and norepinephrine. In addition, amitriptyline has significant anticholinergic and sedative effects. It is adjunctive therapy in numerous chronic pain processes. TCAs are not used in treating these processes. The anticholinergic effects would make urinary retention worse. *Pharmacological Therapies*
- 209. (4)** Pain control is enhanced when pain relief medication is given early rather than after pain is severe. Assess the patient completely upon return from the operating room and periodically thereafter, including pain experience and respiratory status. The patient should be medicated appropriately to treat pain. *Pharmacological Therapies*
- 210. (4)** Suctioning may produce lobar collapse if the suction catheter diameter is too large for the size of the airway. Lobar collapse occurs when air cannot enter the lung from around the catheter while suction is applied; performing intermittent suctioning for no more than 8 seconds at a time and using low pressure reduce the risk of trauma or hypoxia. *Physiological Adaptation*
- 211. (2)** Atmospheric air comprises oxygen, nitrogen, carbon dioxide, and water. Inhaled air is translated into partial pressure of its components. At an altitude of 5000 feet, the partial pressure of arterial O<sub>2</sub> is 65 to 75 mmHg. The pH remains the same regardless of altitude. *Physiological Adaptation*
- 212. (2)** Infants and children depend more heavily on the diaphragm for breathing because the chest wall is softer. They do not inhale twice the air, and they may grunt only when they are in respiratory distress. *Physiological Adaptation*

- 213. (4)** Diuretic induced hypokalemia reduces insulin secretion resulting in elevated blood glucose levels. Blood sugar and potassium levels must be closely monitored in patients with diabetes mellitus who are taking thiazide diuretics. Insulin requires a medical provider order. Thiazide diuretics cause side effects including electrolyte and acid-base disturbances, elevated blood glucose, uric acid, and lipid levels. Thiazides are used in the treatment of fluid overload. They do not prevent the complications of diabetes mellitus. *Pharmacological Therapies*
- 214. (1)** Diarrhea occurs in up to 30 percent of patients and causes about 4 percent of them to stop taking metformin. Metformin inhibits hepatic glucose production. It does not induce hypoglycemia. Options 3 and 4 are not side effects of the medication. *Pharmacological Therapies*
- 215. (1)** Risk factors are those factors that cause a client to be vulnerable to developing a health problem. Depending on the client's needs the nursing interventions may include supporting, counseling, facilitating, teaching, consulting, enhancing the behavior change, and modeling. *Health Promotion and Maintenance*
- 216. (1)** The contemplation stage is the stage in which a person acknowledges having a problem, seriously considers changing a specific behavior, actively gathers information, and verbalizes plans to change the behavior in the near future. Other stages of the Health Behavior Change are: Precontemplation (Readiness for change); Preparation (create a plan of action); Action (substitute health responses for problem behaviors); Maintenance (know danger signs which are usually the result of stress, insufficient coping skills); Termination (new self-image, healthier life-style). *Health Promotion and Maintenance*
- 217. (4)** Pratt's study revealed that families who were most effective in obtaining appropriate medical services and who practiced a wellness lifestyle on their own were the families referred to as "energized" families. These families assertively sought and verified information, made discriminating decisions, and negotiated aggressively with the healthcare system, rather than passively accepting and complying. Many families who do not have insurance are underinsured, preventing them from getting comprehensive healthcare. Furthermore, many poor families who are covered by Medicaid are treated in busy emergency departments and outpatient clinics of public hospitals where care may be fragmented and episodic. There are deleterious outcomes associated with not having health insurance, including a higher mortality rate. *Health Promotion and Maintenance*
- 218. (3)** The family risk genogram is the first section on the Family Focused Health Risk Appraisal (FFHRA). The genogram elicits and organizes a history of the health risk behaviors of the patient's parents and grandparents, which enables the patient to identify familial patterns of risk behavior across two generations. For example, if a patient marks "alcohol" as a risk for his father and also writes alcohol as a risk for his paternal grandparents, a pattern of risk behavior is clearly demonstrated. *Health Promotion and Maintenance*
- 219. (1)** On otoscopic assessment, the tympanic membranes normally appear pearly gray. *Health Promotion and Maintenance*
- 220. (1)** Primary prevention is the administration of vaccine to prevent contracting the disease. If the child is protected by vaccine before exposure to the illness, the illness will not be contracted; there will be no opportunity for lesions to scar and alter body image. Varicella-zoster immune globulin can prevent or significantly modify the disease, helping reduce the chance of scarring lesions. However, varicella-zoster immune globulin is given to immunocompromised children to prevent the more life-threatening clinical manifestations of chickenpox such as encephalitis. Administering oral antihistamines, tertiary prevention, is appropriate to treat itching associated with chickenpox but the best intervention is to prevent contraction of the disease. Aspirin will have no effect on the scarring of the lesions and could precipitate adverse sequelae such as Reye's Syndrome. Aspirin should never be given to children unless ordered by a physician. *Nursing Process*
- 221. (3)** Insulin manufacturers recommend that clumped insulin be discarded and a new vial utilized. Agitating and warming the vial will not eliminate clumped material. Minute clumps may remain which will render the product less effective and promote injection site atrophy. *Pharmacological Therapies*
- 222. (4)** Learning about good nutrition and exercise will maintain physical strength and a sense of well-being. Feeling of waking and having physical strength promotes a positive body image. Exercise and nutritional assistance through support and teaching can help the individual's identity and use of personal strengths; help the high-risk patients maintain a sense of self; changing the self-concept; developing a body image; and developing increased self-esteem. *Psychosocial Integrity*

- 223. (1)** In eating disorders, thinness is a way to control what goes into their body promoting positive body-image and self-worth. Weight consciousness becomes compulsive in 1 of 100 teenaged girls and results in an eating disorder (anorexia nervosa). An eating disorder, i.e., weight loss, muscle wasting, decreased self-esteem. *Psychosocial Integrity*
- 224. (3)** While experiencing vomiting, the client should consume small frequent portions of carbohydrates, including juices and regular (nondietetic) sodas; normal insulin dose should be given, unless medical professionals order differently; the client should try to get extra rest; he should also follow his normal meal plan. If he cannot follow this routine because of stomach upset, he should eat small portions of soft foods (such as regular gelatin or custard) 6–8 times a day. If vomiting or diarrhea persists, he should take liquids every 30 minutes–1 hour and contact his physician; the client should monitor his blood glucose and urine ketone levels every 3–4 hours, not every 6 hours. *Physiological Adaptation*
- 225. (2)** There could be a physical or a psychological problem. In performing an assessment, the nurse can complete a review of systems and consider physical as well as psychological problems; establishing rapport with the client should be done first, then discuss the clinical situation; hypothyroidism has the common presentation of fatigue, slowness, and weight gain; intolerance to cold is characteristic of hypothyroidism. *Physiological Adaptation*
- 226. (1)** Even though a client has had an SCI, the use of a diet high in protein, carbohydrates, and fiber is necessary to prevent both the catabolic process that occurs following SCI and potential problems with bowel function; spinal cord injury is characterized by disrupted transmission of nerve impulses from brain to peripheral nerves. The degree of dysfunction depends on cause, degree of transaction, and level of cord injury; body weight—there is a loss usually attributed to loss of lean body mass; metabolic changes can be dramatic; monitoring fluid, nutrition is a key factor—high protein, low fat diet should be instituted and education of the client and family is very important. *Physiological Adaptation*
- 227. (3)** A client undergoing a BMT will probably be fed by TPN in the posttransplant period due to potential complications affecting the mouth, esophagus, and intestines, leading to diarrhea and malabsorption; supplemental feedings (enteral) are not given, because the client's GI tract has been affected by chemotherapy and other medical treatments. In addition, merely supplementing the client will not provide sufficient calories and nutrients; oral intake is not done due to side effects from high-dose chemotherapy regimens that lead to anorexia, taste perception, nausea, vomiting, and inflammation of mucous membranes; radiation therapy may be administered preoperatively as a primary form of therapy for radiosensitive tumors; chemotherapy is used; the bone marrow is where the blood cells are produced—the bone marrow transplant hopefully will stimulate or replace cells for blood manufacture. *Physiological Adaptation*
- 228. (3)** UAPs are not assigned responsibility and accountability; therefore the overall supervisory responsibility remains with the person making the assignment. Delegation is a type of supervision. Assignments can involve the shift of responsibility and accountability when dealing with other licensed personnel. *Coordinated Care*
- 229. (4)** Family questions may impact assignments depending on the type of questions. The core information for decision making is the staff number, skill mix, and patient acuity. *Coordinated Care*
- 230. (2)** In order for the patient's wishes regarding his healthcare to be known, he needs to define his wishes and document them in a living will and/or durable power of attorney for healthcare. The person designated as his decision-maker should he be unable to make decisions for himself should not be a member of the healthcare team. *Coordinated Care*
- 231. (4)** The nursing shortage currently present in conjunction with the projected shortage in the next three to four decades means that there should be no problem in nurses finding employment. *Coordinated Care*
- 232. (3)** Home care alone without a caregiver in a patient requiring ADL assistance may not be sufficient to maintain function and safety. Adult day care provides care for a limited time period daily and so would not meet the patient's need for full time caregiver assistance. Respite care is short-term care while caregivers rest, and so is not a long-term option for the patient. The most appropriate referral choice for suggestion is therefore long term care with the option of hospice services in the facility. *Coordinated Care*
- 233. (4)** Home care referral requires a consenting patient, a patient with a skilled nursing or therapy need, and a written order by a physician. *Coordinated Care*

- 234. (4)** The verbal wishes of a donor may be followed if known by the person who will be the donor's legal representative should the need arise. While some persons may be waiting for more than one tissue or organ donation, the low number of donations results in seventeen persons who die daily waiting for transplants. The number of tissue or organ donations one donor may make is determined by the amount of donation consented for as well as the medical condition of the donor's organs. *Coordinated Care*
- 235. (2)** Organ recipients and donors are matched for tissue types and organs needed, but not by age and sex. More than 85 percent of adult Americans approve of organ donation. In 2003, 25,640 persons received organ transplants with 5,671 of these being liver transplants. In 2004 there were more than 17,000 persons awaiting liver transplants. *Coordinated Care*
- 236. (3)** is correct as the exception. Guardians are appointed as the legal spokespersons for healthcare and financial decision making when individuals do not have a legal designee and are no longer capable of speaking for themselves. A guardianship may be either permanent or temporary depending on need. *Coordinated Care*
- 237. (3)** is correct. Nurse practice acts set standards for professional nursing practice. They are established by the State Boards of Nursing, who have jurisdiction for licensing nurses and holding them accountable for set standards. Institutions, whether healthcare, educational, or others are held to the standards of practice defined in that state. *Coordinated Care*
- 238. (2)** A client must give consent for Foley catheter insertion, but in most care settings this consent is implied i.e. expressed by the client allowing the procedure to be done. It is covered by a general consent to treatment. Answer(s) 1, 3, and 4 are incorrect. All surgical procedures including gall bladder, pacemaker insertion, and biopsies require a formal written informed consent. *Coordinated Care*
- 239. (2)** The nurse is responsible for obtaining consent usually verbal or implied for the catheterization as a nursing procedure. All consents for surgical procedures including gall bladder, pacemaker insertion, and biopsies need to be obtained by a physician. *Coordinated Care*
- 240. (4)** Any discipline can fill out an incident report if they witness or discover an incident. *Coordinated Care*
- 241. (4)** An incident is any event that is not consistent with routine care of a patient or routine operation of the facility. It is not an error (error implies judgment). Incidents are not necessarily preventable; nor do they have negative outcome. *Coordinated Care*
- 242. (4)** is correct. In the conversation Mrs. Jeffries is expressing her personal wishes which are the right to self determination or autonomy. Since she has expressed her wishes to you, as her nurse you are then ethically obligated by the principle of fidelity, the duty to keep promises to help her. As her advocate, you will promote truthfulness of her expressed opinion by channeling your knowledge of her wishes appropriately, i.e. in conversation with her family, through the physician, your supervisor for assistance/guidance, or other channels identified within the patient care setting. *Coordinated Care*
- 243. (2)** is correct. Recognizing the principle of autonomy, the nurse must support the older adult's decision to return to the setting where the abuse took place, while realizing that his/her own value set may not allow him/her to personally agree that this is in the patient's best interest. Choices 1 and 3 indicate the older adult is in a protected care environment which decreases their vulnerability for harm. Ethically, choice 4 implies justice. *Coordinated Care*
- 244. (4)** Priority setting by the nurse should always include the patient in the decision making whenever possible. A nurse's perception of a priority task may be different than that of a patient's. Respecting the right of autonomy, the patient should be involved in the decision making. *Coordinated Care*
- 245. (4)** Although the process for admission is an important one, in this instance the priority for the nurse becomes intervening on behalf of the patient for comfort. Once the symptoms are alleviated, the patient can then better participate in the rest of the admission process. *Coordinated Care*
- 246. (3)** The trigeminal nerve is responsible for chewing movement. The remaining options are cranial nerves with other functions. *Physiological Adaptation*
- 247. (1)** Widening pulse pressure is a classic sign of increasing intracranial pressure, not the other options. *Physiological Adaptation*

- 248. (4)** Ulnar drift describes a complication of rheumatoid arthritis, where the fingers become bent outwards. The remaining terms describe other types of deformities associated with rheumatoid arthritis. *Reduction of Risk Potential*
- 249. (3)** If a tick is seen on the skin, it should be gently pulled straight out. This will ensure getting all of the tick removed. The other statements are correct and indicate correct understanding of Lyme disease. *Reduction of Risk Potential*
- 250. (3)** This is the only correct response. An intravenous drug abuser may require greater doses of morphine sulfate in order to obtain adequate pain relief. Pain is whatever the client says that it is, and the nurse must respond accordingly. *Reduction of Risk Potential*
- 251. (4)** Eye drops should be administered in the center of the conjunctival sac. If they are placed directly over the cornea, some may cause corneal damage. Pressure over the inner corner of the eye is often held during some eye drop administration, in order to avoid systemic absorption. Instilling into the outer corner of the eye would not facilitate maximal distribution of the medication. *Reduction of Risk Potential*
- 252. (3)** is correct. Only the court can determine incompetency status based on medical and psychological evaluation. Choices 1, 2, and 4 are incorrect. Choice 1 speaks to financial status only, which is not an issue of incompetence. Choice 2 is nonadherence; not incompetence. Choice 4 falsely implies that a nurse may judge incompetence based on his/her perceptions of the quality of decision making. *Coordinated Care*
- 253. (3)** is correct. Patients with this status should have quality symptom management to ensure comfort without efforts for sustaining/prolonging life. Choices 1, 2, and 4 are incorrect. All patients should have equal access to care regardless of code status. Ongoing patient assessment needs to be ongoing to monitor and ensure that comfort goals are met. *Coordinated Care*
- 254. (4)** In utilizing the least restrictive environment for care, the safety issues for this patient should be assessed and, if possible, a family member or caregiver known to the patient should be enlisted to assist in maintaining the patient in safety without restraints. *Coordinated Care*
- 255. (4)** Nursing, through professional organizations and political action, has the opportunity to effect standards of practice, safe staffing laws, and safe workloads. *Coordinated Care*
- 256. (4)** Being an advocate for the profession of nursing includes encouraging and mentoring appropriate persons to become nurses, supporting political issues affecting the profession of nurses such as safe working conditions, following appropriate standards of care for patients, and supporting nursing research by all levels of nurses including clinicians, educators, administrators, and researchers. *Coordinated Care*
- 257. (2)** Discharge planning begins at the time of entry into the healthcare institution in order to adequately plan for and meet the patient's anticipated needs. *Coordinated Care*
- 258. (1)** On home-going after total knee replacement, assistive devices are used for walking and stair climbing until mobility and balance are fully restored and use of the device is discontinued by the physical therapist. All other answers are appropriate. *Coordinated Care*
- 259. (4)** The AHA "Patient Bill of Rights" states that the patient has the right to give informed consent or not to all procedures, and to refuse treatment. *Coordinated Care*
- 260. (2)** The general consent form signed at hospital admission gives consent in general for treatment in the hospital. However, the patient maintains the rights of confidentiality and refusal of treatment. *Coordinated Care*
- 261. (2)** Discharge Planners are licensed social workers or registered nurses with advanced training in organizing and planning for transitions from a healthcare facility to another healthcare facility or home. A master's degree in nursing or medical degree is not required; insurance company representatives may provide information to the discharge planner for use in assisting the patient to choose services. *Coordinated Care*
- 262. (3)** Diagnostic Related Groups are a classification system which relate patients by diagnosis to a hospital or healthcare institution's reimbursements. *Coordinated Care*

- 263. (3)** In a multi-patient room setting, the staff must be especially aware of the potential to breach the patient rights to privacy and confidentiality. *Coordinated Care*
- 264. (2)** This leader is exhibiting an autocratic leadership style. Laissez-faire leadership is passive without overt leadership. Democratic leadership takes information and suggestions from participants for leadership decision-making. Diplomatic leadership is a communication style, not a style of leadership. *Coordinated Care*
- 265. (4)** Education, resource management, feedback on performance for improvement and recognition, and maintenance of the quality of nursing care are all important nursing managerial functions. *Coordinated Care*





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