NCLEX

Exam Questions NCLEX-PN

National Council Licensure Examination(NCLEX-PN)

NEW QUESTION 1
- (Topic 1)
A batterer is usually someone who:

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

Answer: C

Explanation:
Many batterers report having been abused as children.Psychosocial Integrity

NEW QUESTION 2
- (Topic 1)
Which of the following organs of the digestive system has a primary function of absorption?

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

Answer: C

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

NEW QUESTION 3
- (Topic 1)
Teaching the client with gonorrhea how to prevent reinfection and further spread is an example of:

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

Answer: B

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

NEW QUESTION 4
- (Topic 1)
A middle-aged woman tells the nurse that she has been experiencing irregular menses for the past six months. The nurse should assess the woman for other symptoms of:

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

Answer: C

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

NEW QUESTION 5
- (Topic 1)
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

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

Answer: C

Explanation:
Trauma in any client, living or dead, has potential legal and/or forensic implications.

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

NEW QUESTION 6
- (Topic 1)
A primary belief of psychiatric mental health nursing is:

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

Answer: B

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

NEW QUESTION 7
- (Topic 1)
Which of the following is an appropriate nursing goal for a client at risk for nutritional problems?

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

Answer: B

Explanation:
Promoting healthy nutritional practices is an appropriate nursing goal for a client at risk for nutritional
problems. Choice 1 is incorrect because it is a nursing intervention, not a goal statement.
Choice 3 is incorrect
because it is a therapeutic treatment. Choice 4 is incorrect because weight gain is an appropriate goal only if the client is underweight.Basic Care and Comfort

NEW QUESTION 8
- (Topic 1)
A client has been taking alprazolam (Xanax) for four years to manage anxiety. The client reports taking 0.5 mg four times a day. Which statement indicates that the client understands the nurse??s teaching about discontinuing the medication?

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

Answer: C

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

NEW QUESTION 9
- (Topic 1)
Which of the following instructions should the nurse give a client who will be undergoing mammography?

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

Answer: B

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

NEW QUESTION 10
- (Topic 1)
A pregnant Asian client who is experiencing morning sickness wants to take ginger to relieve the nausea. Which of the following responses by the nurse is appropriate?

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

Answer: A

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

NEW QUESTION 10
- (Topic 1)
Which is the proper hand position for performing chest percussion?

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

Answer: A

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

NEW QUESTION 11
- (Topic 1)
When making an occupied bed, it is important for the nurse to:

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

Answer: B

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

NEW QUESTION 12
- (Topic 1)
What is the primary nutritional deficiency of concern for a strict vegetarian?

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

Answer: B

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

NEW QUESTION 14
- (Topic 1)
A 10-month-old child is brought to the Emergency Department because he is difficult to awaken. The nurse notes bruises on both upper arms. These findings are most consistent with:

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

Answer: B

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

NEW QUESTION 15
- (Topic 1)
A client has been diagnosed with Disseminated Intravascular Coagulation (DIC) and transferred to the medical intensive care unit (ICU) subsequent to an acute

bleeding episode. In the ICU, continuous Heparin drip therapy is initiated. Which of the following assessment findings indicates a positive response to Heparin therapy?

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

Answer: B

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

NEW QUESTION 16
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

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

Answer: D

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

NEW QUESTION 17
- (Topic 1)
To remove a client??s gown when she has an intravenous line, the nurse should:

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

Answer: C

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

NEW QUESTION 22
- (Topic 1)
Which of the following values should the nurse monitor closely while a client is on total parenteral nutrition?

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

Answer: C

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

NEW QUESTION 24
- (Topic 1)
Major competencies for the nurse giving end-oflife care include:

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

Answer: A

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

NEW QUESTION 28
- (Topic 1)
When helping a client gain insight into anxiety, the nurse should:

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

Answer: B

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

NEW QUESTION 30
- (Topic 1)
Which of the following is the primary force in sex education in a child??s life?

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

Answer: C

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

NEW QUESTION 34
- (Topic 1)
Following a classic cholecystectomy resection for multiple stones, the PACU nurse observes a serosanguious drainage on the dressing. The most appropriate intervention is to:

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

Answer: C

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

NEW QUESTION 38
- (Topic 2)
The vast majority of deaths resulting from unintentional poisoning occur in:

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

Answer: B

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

NEW QUESTION 43
- (Topic 2)
Central venous access devices (CVADs) are frequently utilized to administer chemotherapy. What is an advantage of using CVADs for chemotherapeutic agent administration?

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

Answer: C

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

setting.Pharmacological Therapies

NEW QUESTION 47
- (Topic 2)
A client can receive the mumps, measles, rubella (MMR) vaccine if he or she:

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

Answer: D

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

NEW QUESTION 48
- (Topic 2)
A nurse is planning a brief treatment program for a client who was raped. A realistic, short- term goal is to:

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

Answer: D

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

NEW QUESTION 51
- (Topic 2)
The nurse is teaching a teenage female about preventing the transmission of genital herpes. Which of the following statements should the nurse include?

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

Answer: C

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

NEW QUESTION 55
- (Topic 2)
In an obstetrical emergency, which of the following actions should the nurse perform first after the baby delivers?

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

Answer: C

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

NEW QUESTION 60
- (Topic 2)
In a disaster situation, the nurse assessing a diabetic client on insulin assesses for all of the following except:

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

Answer: C

Explanation:
Bleeding problems are not characteristic of diabetes. All the other options are appropriate areas of assessment.

Safety and Infection Control

NEW QUESTION 63
- (Topic 2)
The client??s lab culture report is negative for a suspected infection. A test that can correctly identify those who do not have a given disease is:

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

Answer: A

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

NEW QUESTION 64
- (Topic 2)
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

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

Answer: C

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

NEW QUESTION 67
- (Topic 2)
The most effective nursing strategy to assist a client in recognizing and using personal strength includes:

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

Answer: A

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

NEW QUESTION 72
- (Topic 2)
The focus of a nurse case manager is:

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

Answer: B

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

NEW QUESTION 74
- (Topic 2)
A chemical reaction between drugs prior to their administration or absorption is known as:

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

Answer: A

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

NEW QUESTION 78
- (Topic 2)
A client is diagnosed with HIV. Which of the following are antiviral drug classes used in the treatment of HIV/AIDS?

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

Answer: D

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

NEW QUESTION 81
- (Topic 2)
A 17-year-old female was raped by a young man in her neighborhood. She is in the Emergency Department for evaluation and tests. After the procedure is completed, a rape crisis counselor (nurse specialist) talks to the client in a conference room regarding the rape. Implementing counseling by the nurse specialist for the raped victim represents:

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

Answer: B

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

NEW QUESTION 86
- (Topic 2)
People who live in poverty are most likely to obtain health care from:

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

Answer: D

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

NEW QUESTION 88
- (Topic 2)
A 65-year-old female client is experiencing postmenopausal bleeding. Which type of physician should this client be encouraged to see?

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

Answer: B

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

NEW QUESTION 91
- (Topic 3)
Pulling is easier than pushing. So pulling a client rather than pushing him or her has which of the following advantages?

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

Answer: A

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

NEW QUESTION 96
- (Topic 3)
A client describes her cervical mucus as clear, thin, and elastic. Upon examination, the nurse demonstrates that the cervical mucus can be stretched 8–10 cm. The nurse correctly documents the finding as:

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

Answer: C

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

NEW QUESTION 101
- (Topic 3)
Which of the following client groups should the nurse recognize as the fastest-growing segment of the homeless population?

A. single, adult men
B. single mothers with 2 or 3 children
C. runaway adolescents
D. single, adult women

Answer: B

Explanation:
Single mothers with two or three children are the fastest-growing segment of the homeless population. The majority of the children are under the age of five, and the total number of children who are homeless account for more than one-third of the homeless population in the United States. In the past, single adults were the largest group in the homeless population, with more men than women being homeless. Runaway adolescents account for another group of homeless children. Many are victims of abuse or long-term family or school problems.HealthPromotion and Maintenance

NEW QUESTION 102
- (Topic 3)
In teaching bleeding precautions to a client with leukemia, the PN should include which of the following instructions?

A. Use a soft toothbrush.
B. Use dental floss daily.
C. Hold pressure on any scrapes for 1–2 minutes.
D. Use a triple-edged razor.

Answer: A

Explanation:
A soft toothbrush is less likely to cause the gums to bleed than a stiff one. So many white cells are produced in clients with leukemias that other cell types (like platelets) are crowded out, putting the client at risk for bleeding.
Choice 2 is incorrect because dental floss is contraindicated; it can make the gums bleed.
Choice 3 is incorrect because when clotting is impaired, pressure should be held for 5–10 minutes or longer, until the bleeding stops.
Choice 4 is incorrect because an electric razor should be used to prevent small cuts.
Physiological Adaptation

NEW QUESTION 104
- (Topic 3)
A client has a nasogastric (NG) tube in place following abdominal surgery. The purpose of this tube immediately following surgery is to:

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

Answer: C

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

NEW QUESTION 105
- (Topic 3)
Perineal care to a female client by the nurse can be performed:

A. without gloves, pouring water from a sterile bottle.
B. without gloves, having the client perform all care.
C. with gloves, washing the perineal area from front to back.

D. with gloves, washing the perineal area from back to front.

Answer: C

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

NEW QUESTION 107
- (Topic 3)
When the nurse is determining the appropriate size of a nasopharyngeal airway to insert, which body part should be measured on the client?

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

Answer: D

Explanation:
A nasopharyngeal airway is measured from the tip of the nose to the earlobe.Reduction of Risk Potential

NEW QUESTION 109
- (Topic 3)
A client receiving drug therapy with furosemide and digitalis requires careful observation and care. In planning care for this client, the nurse should recognize that which of the following electrolyte imbalances is most likely to occur?

A. hyperkalemia
B. hypernatremia
C. hypokalemia
D. hypomagnesemia

Answer: C

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

NEW QUESTION 111
- (Topic 3)
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?

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

Answer: C

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

NEW QUESTION 112
- (Topic 3)
An Rh-negative woman with previous sensitization has delivered an Rh-positive fetus. Which of the following nursing actions should be included in the client??s care plan?

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

Answer: A

Explanation:
If a woman is sensitized to the Rh factor, it poses a threat to any Rh-positive fetus she delivers. The nurse

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

NEW QUESTION 116
- (Topic 3)
Incidences of child abuse apperar to be higher in the African-American community and might be explained by:

A. the increased number of African Americans viewing violence on television.
B. more single-parent households in African- American communities.
C. stricter child-rearing practices in African- American households.
D. a higher occurrence of rage in African Americans.

Answer: B

Explanation:
Child abuse is higher in households with lower socioeconomic status and single parents. The increased incidence might be due to increased stress and fewer support systems. Psychosocial Integrity

NEW QUESTION 120
- (Topic 3)
Which medication might the physician order if the client expresses discomfort with being in the enclosed space of a CT scanner?

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

Answer: A

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

NEW QUESTION 122
- (Topic 3)
To ensure proper immobilization and increase client comfort when using a rigid splint:

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

Answer: C

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

NEW QUESTION 126
- (Topic 3)
Which of the following procedures describes an opening between the colon and abdominal wall?

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

Answer: C

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

NEW QUESTION 129
- (Topic 3)
Which of the following tests is commonly performed on newborns with jaundice?

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

Answer: C

Explanation:

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

NEW QUESTION 130
- (Topic 3)
An elevation in which of the following enzymes is indicative of pancreatitis?

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

Answer: D

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

NEW QUESTION 133
- (Topic 3)
Clients who take iron preparations should be warned of the possible side effects, which might include:

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

Answer: B

Explanation:
Oral iron preparations are often used to treat clients who have iron deficiency anemia to regain a positive iron balance. These preparations need to be supplemented with adequate dietary intake of iron.
It can take 2–3 weeks to see improvement and up to 6–10 months to return to a stable iron level after a deficiency exists. The most common adverse effects associated with oral iron intake are related to direct GI upset, anorexia, nausea, vomiting, diarrhea, dark stools, and constipation. Nursing comfort measures include taking the preparations with meals, teaching about black stools, encouragement, and proper nutrition.Physiological Adaptation

NEW QUESTION 136
- (Topic 3)
When a client with a major burn experiences body image disturbance, which of the following is an appropriate nursing intervention classification?

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

Answer: A

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

NEW QUESTION 139
- (Topic 3)
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

A. Advil
B. Aleve
C. Toradol
D. Bextra

Answer: C

Explanation:
Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM, IV, or PO.Basic Care and Comfort

NEW QUESTION 143
- (Topic 3)
Which of the following foods present a problem for a client diagnosed with Celiac Disease?

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

Answer:

B

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

NEW QUESTION 147
- (Topic 3)
When suctioning a client, what is the usual amount of time the nurse should spend for each suction pass?

A. 2 seconds
B. 10 seconds
C. 20 seconds
D. 30 seconds

Answer: B

Explanation:
Ten seconds is the usual amount of time the nurse should spend for each suction pass.
Two seconds is not enough time to remove secretions. The remaining choices are too long and could lead to hypoxia and tissue trauma.Reduction of Risk Potential

NEW QUESTION 151
- (Topic 3)
Which of the following statements by a client with gastroesophageal reflux disease (GERD) indicates adequate understanding?

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

Answer: C

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

NEW QUESTION 155
- (Topic 3)
Which is the most common microorganism associated with gastritis?

A. syphilis
B. cytomegalovirus
C. pylori
D. mycobacterium

Answer: C

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

NEW QUESTION 158
- (Topic 3)
Hazards of improper splinting include:

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

Answer: D

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

NEW QUESTION 160
- (Topic 3)
A client is having problems with her ankles. To assess her ankles?? ROM, which ROM exercises should the nurse have her perform?

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

Answer: D

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

NEW QUESTION 163
- (Topic 3)
A Roman Catholic client is preparing to have magnetic resonance imaging. He wants to wear his metal crucifix pendant while he is receiving the test. Which of the following is an appropriate response by the nurse?

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

Answer: C

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

NEW QUESTION 165
- (Topic 3)
Which of the following is a predisposing factor for cancer of the tongue?

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

Answer: A

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

NEW QUESTION 167
- (Topic 3)
The nurse who was not promoted then went to the utility room and slammed several cupboard doors while looking for Kleenex. This behavior exemplifies:

A. displacement.
B. sublimation.
C. conversion.
D. reaction formation.

Answer: A

Explanation:
Displacement unconsciously transfers emotions associated with a person, object, or situation to another lessthreatening person, object, or situation. The nurse slammed doors instead of striking the promoted nurse or the administrator who made the promotion decision. Sublimation is the unconscious process of substituting constructive activity for unacceptable impulses. This choice cannot be considered correct because the slamming of the cupboard doors cannot be considered a constructive activity. Conversion involves unconsciously transforming anxiety into a physical symptom. Reaction formation keeps unacceptable feelings or behaviors out of awareness by using the opposite feeling or behavior.Psychosocial Integrity

NEW QUESTION 171
- (Topic 3)
When working with multicultural populations, the nurse should consider all of the following when planning care for a client with an altered sexuality pattern except:

A. some members of the Hispanic and Native- American cultures are very open when discussing sexuality.
B. some cultures view the postpartum period as a state of impurity.
C. some women in the African-American culture view childbearing as a validation of their femaleness.
D. some Native-American women believe monthly menstruation maintains physical well- being and harmony.

Answer: A

Explanation:
Many cultures (including the Hispanic and Native-American cultures) are sometimes hesitant to discuss sexuality. Some Navajos, Hispanics, and Orthodox Jews view the postpartum period as a state of impurity and might seclude women as long as they are bleeding. The seclusion is usually ended with a ritual bath. Many white teenage girls approve of the prevention of pregnancy, and many African-American teenage girls value pregnancy. Many Native-American women believe in the importance of monthly menstruation to maintain physical wellbeing and harmony.Health Promotion and Maintenance

NEW QUESTION 172
- (Topic 4)
Referral for client education in the community can be accomplished through all of the following except:

A. community agencies such as the American Heart Association.
B. parish nurses.

C. home health care agencies.
D. unlicensed massage therapists.

Answer: D

Explanation:
Client education should be completed by an individual or individuals with acknowledged expertise in the subject area and credentials to support activity within the health care community.Coordinated Care

NEW QUESTION 173
- (Topic 4)
In the United States, several definitions of death are currently being used. The definition that uses apnea testing and pupillary responses to light is termed:

A. whole brain death.
B. heart-lung death.
C. circulatory death.
D. higher brain death.

Answer: A

Explanation:
Most protocols require two separate clinical examinations, including induction of painful stimuli, papillary responses to light, oculovestibular testing, and apnea testing. Choices 2 and 4 have no specific test required. Choice 3 is not a current definition of death in the United States.Psychosocial Integrity

NEW QUESTION 176
- (Topic 4)
Levothyroxine (Synthroid) is the drug of choice for thyroid replacement therapy in clients with hypothyroidism because:

A. it is chemically stable, nonallergenic, and can be administered orally once a day.
B. it is available in a single 25mg tablet, which makes dosing simple.
C. it is not a prodrug.
D. it has a short half-life.

Answer: A

Explanation:
Levothyroxine is safe and effective with virtually no side effects when dosed properly. A single, daily dose is possible because of the long half-life (7 days). Levothyroxine tablets are available in a wide range of concentrations to meet individual client requirements. Levothyroxine (T4) is a prodrug of T3.Pharmacological Therapies

NEW QUESTION 180
- (Topic 4)
The nurse uses prioritization to determine all the following except:

A. time allotment for certain tasks.
B. appropriate interventions.
C. treatment procedures.
D. the need for client education.

Answer: C

Explanation:
Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure to be compliant with practice standards. Established priorities contribute to the determination of time management, appropriate interventions, and the need for client education as a potential intervention.Coordinated Care

NEW QUESTION 182
- (Topic 4)
The intravenous route is potentially the most dangerous route of drug administration because:

A. the IV might infiltrate.
B. it is expensive and nursing intensive.
C. rapid administration of a drug can lead to toxicity.
D. the client always has more side effects.

Answer: C

Explanation:
The bioavailability of the injected medication is 100% and might lead to toxicity. An IV infiltration can cause serious problems with tissue necrosis, but this is not life threatening. Expensiveandtime consumingdo not equate withdangerous. Choice 4 is not always true. Pharmacological Therapies

NEW QUESTION 183
- (Topic 4)
Some drugs are excreted into bile and delivered to the intestines. Prior to elimination from the body, the drug might be absorbed. This process is known as:

A. hepatic clearance.
B. total clearance.

C. enterohepatic cycling.
D. first-pass effect.

Answer: C

Explanation:
Drugs and drug metabolites with molecular weights higher than 300 can be excreted via the bile, stored in the gallbladder, delivered to the intestines by the bile duct, and then reabsorbed into the circulation. This process reduces the elimination of drugs and prolongs their half-life and duration of action in the body. Choice 1 is the amount of drug eliminated by the liver. Choice 2 is the sum of all types of clearance including renal, hepatic, and respiratory. Choice 4 is the amount of drug absorbed from the GI tract, then metabolized by the liver (reducing the amount of drug that makes it into circulation).Pharmacological Therapies

NEW QUESTION 187
- (Topic 4)
A nurse is teaching a group of clients with a diagnosis of Schizophrenia who are nearing discharge from a residential care facility. An essential topic to include is:

A. pathophysiology of the disease and expected symptoms.
B. how to recognize and manage symptoms of relapse.
C. the need to take extra medication when feeling stressed.
D. the importance of contact with follow-up care daily.

Answer: B

Explanation:
Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed, and might become withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone who is trusted, avoid negative people, and decrease stimuli and stress.Psychosocial Integrity

NEW QUESTION 191
- (Topic 4)
Acute hyphema is associated with what type of injury?

A. orthopedic
B. eye
C. insect sting or snakebite
D. gynecological trauma

Answer: B

Explanation:
An acute hyphema occurs as a result of a blunt injury to the eye and is manifested by a half-moon appearance or a horizontal line across the globe when the client is upright (due to blood collected in the anterior chamber).Safety and Infection Control

NEW QUESTION 193
- (Topic 4)
The nurse can best communicate to a client that he or she has been listening by:

A. restating the main feeling or thought the client has expressed.
B. making a judgment about the client??s problem.
C. offering a leading question such as, ??And then what happened???
D. saying, ??I understand what you??re saying.??

Answer: A

Explanation:
Restating allows the client to validate the nurse??s understanding of what has been communicated. It??s an active listening technique. Regarding Choice 2, judgments should be suspended in a nurse-client relationship. Choice 3 is incorrect because leading questions ask for more information rather than showing understanding. Choice 4 communicates understanding, but the client has no way of measuring the understanding.
PsychosocialIntegrity

NEW QUESTION 197
- (Topic 4)
The three major sequential maturational crises for females include:

A. puberty, pregnancy, and menopause.
B. death of a spouse, menopause, and childbirth.
C. rape, divorce, and menarche.
D. dating, engagement, and separation.

Answer: A

Explanation:
The three major sequential maturational crises affecting females are puberty, pregnancy, and menopause. These are life events that have been studied by many researchers and are considered the major events in a woman??s life. Puberty is the onset menarche. Pregnancy is a turning point in one??s life from which there is no return. Menopause is the cessation of menses. The nurse has the responsibility to assess, plan, implement appropriate concepts to facilitate effective functioning, and enhance growth and development. Choices 2, 3, and 4 are not sequential maturational crises.Psychosocial Integrity

NEW QUESTION 201
- (Topic 4)
To improve overall health, the nurse should place highest priority on assisting a client to make lifestyle changes for which of the following habits?

A. drinking a six-pack of beer each day
B. eating an occasional chocolate bar
C. exercising twice a week
D. using relaxation exercises to deal with stress

Answer: A

Explanation:
Health promotion is motivated by the desire to increase people??s well-being and health potential. The nurse promotes health by maximizing the client??s own strengths. Identification and analysis of the client??s strengths are a component of preventing illness, restoring health, and facilitating coping with disability or death. The nurse facilitates decisions about lifestyle that enhance one??s quality of life and encourage acceptance of responsibility for one??s own health.Health Promotion and Maintenance

NEW QUESTION 203
- (Topic 4)
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Answer: D

Explanation:
A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

NEW QUESTION 206
- (Topic 4)
Kleinman??s Explanatory Model of Health and Illness is significant because:

A. it explains what kind of health beliefs a family is likely to have.
B. it brings out the importance of culture in forming health explanations.
C. it discusses the important role that popular and folk domains of influence have.
D. it has an educational base to the structure.

Answer: C

Explanation:
The anthropologist Kleinman makes a distinction between disease and illness. Disease is the health care professionals?? biomedical understanding of the health problem, while illness is the client??s personal and unique understanding and definition of what is happening to him. The theorist states that cultural factors determine the importance of the various domains of influence.Health Promotion and Maintenance

NEW QUESTION 207
- (Topic 4)
The nurse??s first action upon discovery of an electrical fire should be which of the following?

A. Disconnect the electrical power if it can be performed safely.
B. Smother the source with an object such as a blanket.
C. Saturate the source with water or other readily available liquid.
D. Activate the fire alarm immediately.

Answer: A

Explanation:
If it is safe to do so, the nurse should disconnect electrical devices from the power source.
Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire,just as water or other liquids might incite an explosion or flames. The fire alarm should be activated promptly, and this should be the next action after disconnecting the electrically powered equipment.Safety and Infection Control

NEW QUESTION 208
- (Topic 4)
A complication of total parenteral nutrition (TPN) is the development of cholestasis. What is this condition?

A. an inflammatory process of the extrahepatic bile ducts
B. an arrest of the normal flow of bile
C. an inflammation of the gallbladder
D. the formation of gallstones

Answer: B

Explanation:
Cholestasis due to TPN administration is an intrahepatic process that interrupts the normal flow of bile. Extrahepatic bile duct inflammation is cholangitis.

Inflammation of the gallbladder is cholecystitis. Gallstones are formed by bile components.Pharmacological Therapies

NEW QUESTION 211
- (Topic 4)
A client??s central venous access device (CVAD) becomes infected. Why might the physician order antibiotics to be given through the line rather than through a peripheral IV line?

A. to prevent infiltration of the peripheral line
B. to reduce the pain and discomfort associated with antibiotic administration in a small vein
C. to lessen the chance of an allergic reaction to the antibiotic
D. to attempt to eliminate microorganisms in the catheter and prevent having to remove it

Answer: D

Explanation:
Microorganisms that infect CVADs are often coagulase-negative staphylococci, which can be eliminated by antibiotic administration through the catheter. If unsuccessful in eliminating the microorganism, the CVAD must be removed. CVAD use lessens the need for peripheral IV lines and thus the risk of infiltration. In this case, however, the antibiotics are given to eradicate microorganisms from the CVAD. CVAD use has the effect described in Choice 2, but in this case, the antibiotics are given through the CVAD to eliminate the infective agent. The route does not prevent an allergic reaction.Pharmacological Therapies

NEW QUESTION 212
- (Topic 4)
A client goes to the mental health center for difficulty concentrating, insomnia, and nightmares. The client reports being raped as a child. The nurse should assess the client for further signs of:

A. general anxiety disorder.
B. schizophrenia.
C. post-traumatic stress disorder.
D. bipolar disorder.

Answer: C

Explanation:
Childhood sexual abuse is associated with adult-onset depression and with an increased risk for lifetime and current post-traumatic stress disorder (PTSD). About one-third of all victims of sexual abuse meet the diagnostic criteria for PTSD. A person with PTSD has three main types of symptoms: (1) Re-experiencing the traumatic event with flashbacks, nightmares, and exaggerated reactions to triggers that remind the person of the event. (2) Emotional numbing is evidenced by avoidance of activities, places, thoughts, feelings, or conversations related to the trauma; feelings of detachment from others; and restricted or blunted emotions. (3) Increased activity is seen in bursts of anger, difficulty sleeping, hypervigilence, difficulty concentrating, and an exaggerated startle response. Other problems associated with PTSD are panic attacks, suicidal thoughts and feelings, substance abuse, eating disorders, feelings of alienation and isolation, and feelings of mistrust and betrayal.Psychosocial Integrity

NEW QUESTION 215
- (Topic 4)
The emergency triage nurse should perform which action upon receiving the history that a client has a severe cough, fever, night sweats, and body wasting?

A. Place the client in the waiting room until an available cubicle is open.
B. Seclude the client from other clients and visitors.
C. Perform no intervention because it might not be necessary until tests confirm a disease.
D. Don gown, gloves, and mask immediately.

Answer: B

Explanation:
The client is describing signs and symptoms of tuberculosis. The client is potentially infectious to others and should be secluded. A respirator mask should be worn by caregivers, but it is not necessary for the nurse to don a gown and gloves. If the client is moved to other areas such as radiology, a mask should be worn by the client and a respirator mask should be worn by those working in close contact with the client.Safety and Infection Control

NEW QUESTION 217
- (Topic 4)
Activities of effective supervisors can be taskrelated or people-related activities. An example of a task-related supervisory activity is:

A. coaching.
B. evaluating.
C. delegating.
D. facilitating.

Answer: C

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

NEW QUESTION 218
- (Topic 4)
Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

A. primary prevention.
B. secondary prevention.

C. tertiary prevention.
D. disability prevention.

Answer: B

Explanation:
The three levels of prevention address disease and disability across all phases, from absence of disease and at risk for disease, to preventing further impairment. Hearing impairment associatedwith prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.Safety and Infection Control

NEW QUESTION 220
- (Topic 4)
A woman is in the active phase of labor. An external monitor has been applied, and a fetal heart deceleration of uniform shape is observed, beginning just as the contraction is under way and returning to the baseline at the end of the contraction. Which of the following nursing actions is most appropriate?

A. Administer O2.
B. Turn the client on her left side.
C. Notify the physician.
D. No action is necessary.

Answer: D

Explanation:
It is an early deceleration as a result of head compression, and at this time no action is necessary. Close observation of the mother and baby is needed.Physiological Adaptation

NEW QUESTION 223
- (Topic 4)
The power a nurse exerts when he or she works to accomplish goals and effect change in an agency or in policy is considered what type of power?

A. political
B. personal
C. positional
D. professional

Answer: A

Explanation:
Political power results from one??s ability to work within systems, agencies, or through policy to affect change. Personal power is based on one??s charisma and self-confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based on one??s professional skills and abilities resulting from one??s recognized expertise in an area of practice.Coordinated Care

NEW QUESTION 228
- (Topic 4)
A day care center has asked the nurse to provide education for parents regarding safety in the home. What type of preventive care does this represent?

A. primary
B. secondary
C. tertiary
D. health promotion

Answer: A

Explanation:
Primary prevention involves activities that are utilized to promote wellness or prevent illness or injury. There are many dangers in the home for small children. Providing education regarding the need for safety measures to prevent injury in the home is considered primary prevention. Secondary prevention involves early detection of a disease or illness and quick intervention to aid the client in maintenance of the disease or injury. Tertiary prevention involves the reduction of a disability and the promotion of the highest level of functioning for a client in relation to his or her disease or injury. Health promotion is any activity that increases a client??s health and wellness.Health Promotion and Maintenance

NEW QUESTION 232
- (Topic 5)
All of the following are clinical manifestations indicating male climacteric except:

A. hot flashes.
B. loss of reproductive ability.
C. headaches.
D. heart palpitations.

Answer: B

Explanation:
The likelihood of fathering children does decrease with aging and decreased testosterone production, but men do not lose their ability to reproduce during the climacteric. Many men do not experience any physical symptoms of climacteric but some men do report hot flashes, headaches, and heart palpitations, among other symptoms.Health Promotion and Maintenance

NEW QUESTION 237
- (Topic 5)
Which is an appropriate outcome for the nursing diagnosis of Body Image Disturbance for a client with anorexia nervosa?

A. The client verbalizes knowledge of a maintenance diet.
B. The client demonstrates assertiveness with family.
C. The client verbalizes her body size accurately.
D. The client demonstrates control of obsessive behaviors.

Answer: C

Explanation:
Part of the problem for anorexic clients is an altered view of their body appearance (visualizing themselves as fat even when they are emaciated). Choice 1 involves a knowledge deficit. Choice 2 involves possible resolution of family-dynamic issues. Choice 4 involves psychological adaptation.Basic Care and Comfort

NEW QUESTION 239
- (Topic 5)
What are the implications for a client with renal insufficiency who wants to start a low- carbohydrate (CHO) diet?

A. As long as the client eats a minimum of 30g of CHO/day, there should be no problem.
B. The client??s clinical condition is a contraindication to starting a low CHO diet.
C. Calcium supplements should be utilized to prevent the development of osteoporosis while on a low CHO diet.
D. As long as the client eats foods that are high biologic protein sources, a low CHO diet can be followed.

Answer: B

Explanation:
A client with renal insufficiency should not start a low CHO diet because it could result in an increased renal solute load. Clients who have renal disease (renal failure, endstage renal disease [ESRD], dialysis, and transplant) or liver disease (liver failure, hepatic encephalopathy, cirrhosis, transplant, and hepatitis) require some form of protein control in dietary patterns to preventcomplications from an inability to handle protein solute load. Proteins used in the diet must be of high biologic value, and protein intake is usually weight based, starting at 0.8 g/kg of dry weight, depending on the client??s underlying clinical condition. Protein levels may be increased as necessary to account for metabolic response to dialysis and regeneration of liver tissue (1.5–2.0 g/kg/day). A minimum level of CHOs are needed in the diet (50–100 g/day) to spare protein. Vitamin and mineral supplements might be indicated with clients who have liver failure. The dietician is instrumental in calculating specific nutrient requirements for these clients and reviewing fluid intake and output, medication profile, and daily weight to monitor client outcomes in conjunction with dialysis technicians and nurses.Physiological Adaptation

NEW QUESTION 243
- (Topic 5)
A female prostitute enters a clinic for treatment of a sexually transmitted disease. This disease is the most prevalent STD in the United States. The nurse can anticipate that the woman has which of the following?

A. herpes
B. chlamydia
C. gonorrhea
D. syphilis

Answer: B

Explanation:
Epidemiological studies indicate that chlamydia is the most prevalent sexually transmitted disease in the United States.Physiological Adaptation

NEW QUESTION 248
- (Topic 5)
Which of the following home-care strategies is most likely to negatively impact the body image of a client with Cushing??s syndrome?

A. providing safety measures to prevent falls
B. taking medications as prescribed
C. wearing a medical ID indicating Cushing??s syndrome
D. having regular health assessments

Answer: C

Explanation:
All of the strategies listed are included in home care for the client with Cushing??s syndrome. Choice 3 is the best answer because wearing a medical ID is a visible sign that something is wrong and a constant reminder to the client that he or she has a loss of body function.
Choice 1 might enhance body image because it prevents falls that could cause further injury and debilitation. Taking medications as prescribed should enhance body image because it decreases the symptoms present. Having regular health assessments indicates an enhanced body image because it signals the desire to take care of the body and keep it at its best.Health Promotion and Maintenance

NEW QUESTION 249
- (Topic 5)
Which cultural group has the highest incidence of inflammatory bowel disease (IBD)?

A. Asians
B. Caucasians
C. Hispanics
D. African Americans

Answer:

B

Explanation:
Caucasians have the highest incidence of inflammatory bowel disease (IBD).Reduction of Risk Potential

NEW QUESTION 253
- (Topic 5)
A client is to have an enema to reduce flatus. The enema tube should be inserted:

A. 4 inches.
B. 6 inches.
C. 2 inches.
D. 8 inches.

Answer: A

Explanation:
Enema tubing must be passed beyond the internal sphincter. Two inches is not far enough to pass the internal sphincter. Both 6 and 8 inches are too far and might cause trauma to the bowel.Basic Care and Comfort

NEW QUESTION 256
- (Topic 5)
The teaching plan for a postpartum client who is about to be discharged should include which of the following instructions?

A. ??It is normal for your breasts to be tende
B. You should call the physician if you also have redness and fatigue.??
C. ??Because your baby was delivered vaginally, you might have to urinate more frequently.??
D. ??It is normal to run a low-grade temperature for a few day
E. If it is higher than 100?? F, call your physician.??
F. ??Be sure to call your physician if your vaginal discharge becomes bright red.??

Answer: D

Explanation:
The vaginal discharge after birth is called lochia, and it changes from red (rubra) to serosa (clear) on the third postpartum day. If it returns to red or contains clots, it could signal impending hemorrhage or infection and the physician should be notified. It is not normal for the breasts to be tender. If the breasts become engorged, they might be tender and the mother might need to be given additional instructions on breast care. Tenderness, redness, and fatigue are clinical manifestations of mastitis and should be reported to the physician. A woman should void in normal patterns and frequency after birth. Increased frequency is a sign of a urinary tract infection and should be reported to the physician. By the time of discharge, the woman??s temperature should be normal. Elevations should be reported to the physician.Health Promotion and Maintenance

NEW QUESTION 258
- (Topic 5)
Which type of exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence?

A. Kegel
B. resistance
C. passive
D. stretching

Answer: A

Explanation:
Kegel exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence.Physiological Adaptation

NEW QUESTION 262
- (Topic 5)
Which of the following is not a function of parathyroid hormone?

A. moving calcium from bones to the bloodstream
B. promoting renal tubular reabsorption of phosphorus
C. promoting renal tubular reabsorption of calcium
D. enhancing renal production of vitamin D metabolites

Answer: B

Explanation:
Parathyroid hormone depresses renal tubular reabsorption of phosphorus. All of the other choices are functions of parathyroid hormone.Reduction of Risk Potential

NEW QUESTION 267
- (Topic 5)
The nurse is using Cognitive-Behavioral methods of pain control and knows that the these methods can be expected to do all the following except:

A. completely relieve all pain.
B. provide benefit by restoring the client??s sense of self-control.
C. help the client to control symptoms.

D. help the client actively participate in his or her own care.

Answer: A

Explanation:
These interventions (strategies) help the client in all areas of client well-being. Focusing on perception and thought, cognitive techniques are designed to influence how one interprets events and bodily sensations.BasicCare and Comfort

NEW QUESTION 268
- (Topic 5)
The nurse should utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

A. triceps skinfold measurement
B. fasting blood glucose level
C. hemoglobin A1c level
D. serum lipid profile results

Answer: A

Explanation:
Objective anthropometric measurements such as triceps skinfold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. While all the other choicesrepresent tests that might provide useful information, they also might be affected by variables other than malnutrition.Physiological Adaptation

NEW QUESTION 269
- (Topic 5)
Pain tolerance in an elderly client with cancer should:

A. Stay the same.
B. Decrease.
C. Increase.
D. Cancer should have no effect on pain tolerance for an elderly client.

Answer: B

Explanation:
There is potential for a lowered pain tolerance to exist with diminished adaptative capacity.
Basic Care and Comfort

NEW QUESTION 274
- (Topic 5)
As part of the teaching plan for a client with type I diabetes mellitus, the nurse should include that carbohydrate needs might increase when:

A. an infection is present.
B. there is an emotional upset.
C. a large meal is eaten.
D. active exercise is performed.

Answer: D

Explanation:
Active exercise increases insulin sensitivity, thus lowering blood glucose levels. Additional carbohydrates might be needed to balance the usual insulin dose. All of the other choices increase blood glucose levels.BasicCare and Comfort

NEW QUESTION 275
- (Topic 5)
Which of the following diseases places a client at risk for developing cirrhosis?

A. type I diabetes
B. alcoholism
C. leukemia
D. glaucoma

Answer: B

Explanation:
Alcoholism places a client at risk for developing cirrhosis. None of the other choices are related to cirrhosis.Physiological Adaptation

NEW QUESTION 278
- (Topic 5)
When a client wishes to improve her appearance by removing excess skin from her face and neck, the nurse should provide teaching regarding which of the following procedures?

A. dermabrasion
B. rhinoplasty
C. blepharoplasty
D. rhytidectomy

Answer: D

Explanation:
Rhytidectomy is the procedure for removing excess skin from the face and neck. It is commonly called a face-lift. Dermabrasion involves the spraying of a chemical to cause light freezing of the skin, which is then abraded with sandpaper or a revolving wire brush. It is used to remove facial scars, severe acne, and pigment from tattoos. Rhinoplasty is performed to improve the appearance of the nose and involves reshaping the nasal skeleton and overlying skin. Blepharoplasty is the procedure that removes loose and protruding fat from the upper and lower eyelids.Health Promotion and Maintenance

NEW QUESTION 279
- (Topic 5)
Elderly persons with pernicious anemia should be instructed:

A. to increase their dietary intake of foods high in B12.
B. that they do not need to return for follow-up for at least a month after initiation of treatment.
C. that oral B12 is safer and less expensive than parenteral replacement.
D. that diarrhea can be a transient side effect of B12 injections.

Answer: D

Explanation:
Pernicious anemia is a megaloblastic, macrocytic, normochronic anemia caused by a deficiency of the intrinsic factor produced by the stomach. This results in malabsorption of vitamin B12, which is necessary for DNA synthesis and maturation of RBC. Education should include side effects of Vitamin B12, which can include pain and burning at the injection site, peripheral vascular thrombosis, and transient diarrhea. PhysiologicalAdaptation

NEW QUESTION 281
- (Topic 6)
A patient has been diagnosed with diabetes mellitus. Which of the following is not a clinical sign of diabetes mellitus?

A. Polyphagia
B. Polyuria
C. Metabolic acidosis
D. Lower extremity edema

Answer: D

Explanation:
A-C are associated with diabetes mellitus.

NEW QUESTION 284
- (Topic 6)
A mother has come to the pediatric clinic concerned about the recent outbreak of West Nile Virus. The ages of her children are 5, 7, and 10. The mother has asked the nurse what she can do to prevent her children from contracting this illness. Which piece of information is best to provide the mother with?

A. The children should wear long sleeves and long pants while outside.
B. Apply insect repellant containing DEET when the children are outside.
C. Remove standing water from the property.
D. All of the above.

Answer: D

Explanation:
It is recommended that the children wear insect repellant containing DEET and long-sleeve shirts and long pants when they are outside. Removing standing water from areas around where the children play can help decrease the number of breeding mosquitoes. These are the only known methods of prevention at this time.Health Promotion and Maintenance

NEW QUESTION 289
- (Topic 6)
A client has been taking a drug (Drug A) that is highly metabolized by the cytochrome p- 450 system. He has been on this medication for 6 months. At this time, he is started on a second medication (Drug B) that is an inducer of the cytochrome p-450 system. You should monitor this client for:

A. increased therapeutic effects of Drug A.
B. increased adverse effects of Drug B.
C. decreased therapeutic effects of Drug A.
D. decreased therapeutic effects of Drug B.

Answer: C

Explanation:
Drug B induces the cytochrome p-450 enzyme system of the liver, thus increasing the metabolism of Drug A. Therefore, Drug A is broken down faster and exerts decreased therapeutic effects. Drug A is metabolized faster, thus reducing, not increasing, its therapeutic effect. Inducing the cytochrome p-450 system does not increase the adverse effects of Drug B. Drug B induces the cytochrome p-450 system but is not metabolized faster. Thus, the therapeutic effects of Drug B are not decreased.Pharmacological Therapies

NEW QUESTION 290
- (Topic 6)
The difference between spirituality and religion is that spirituality is:

A. a belief about a higher power.
B. an individual??s relationship with a higher power.
C. organized worship.
D. a belief in an invisible energy or ideal.

Answer: B

Explanation:
Religion can be considered a system of beliefs, practices, and ethical values about a divine or superhuman power or powers worshipped as the creator(s) and ruler(s) of the universe. Spirituality is a belief in or relationship with some higher power, creative force, driving being, or infinite source of energy.Psychosocial Integrity

NEW QUESTION 293
- (Topic 6)
A young female teenager describes a brutal assault and rape to the nurse on duty. Which of the following actions should the nurse take first?

A. Check with case manager on duty about possible police intervention.
B. Provide an environment of concern and emotional stabilization.
C. Clean the patient??s wounds with normal saline and gauze.
D. Recommend a good attorney to the patient.

Answer: B

Explanation:
Emotional support is what that patient needs most at this point in time.

NEW QUESTION 296
- (Topic 6)
A client was involved in a motor vehicle accident in which the seat belt was not worn. The client is exhibiting crepitus, decreased breath sounds on the left, complains of shortness of breath, and has a respiratory rate of 34/min. Which of the following assessment findings should concern the nurse the most?

A. temperature of 102?? F and a productive cough
B. arterial blood gases (ABGs) with a PaO2 of 92 and PaCO2 of 40 mmHg
C. trachea deviating to the right
D. barrel-chested appearance

Answer: C

Explanation:
A mediastinal shift is indicative of a tension pneumothorax along with theother symptoms in the question.Because the individual was involved in an MVA, assessment is targeted at acute traumatic injuries to the lungs, heart, or chest wall rather than other conditions indicated in the other choices. Choice 1 is common with pneumonia. Values in Choice 2 are not alarming. Choice 4 is typical of someone with chronic obstructive pulmonary disease (COPD). A tensionpneumothorax is a dangerous complication and a medical emergency where entering air cannot escape by the same route and pressure within the pleural cavity increases, resulting in complete collapse of the lung. A mediastinal shift to the unaffected side and a downward displacement of the diaphragm can be observed.
Physiological Adaptation

NEW QUESTION 298
- (Topic 6)
A nurse is caring for a retired MD. The MD asks the question, ??What type of cells secrete insulin??? The correct answer is:

A. alpha cells
B. beta cells
C. CD4 cells
D. helper cells

Answer: B

Explanation:
Beta cells secrete insulin.

NEW QUESTION 301
- (Topic 6)
A nurse has been ordered to administer Morphine to a patient. Which of the following effects is unrelated to Morphine??s effects on the patient?

A. Depressed function of the CNS
B. Increased blood flow
C. Decreased venous capacity
D. Pain relief

Answer: C

Explanation:
Venous capacity increases with morphine use.

NEW QUESTION 302
- (Topic 6)
A client begins bleeding from the site of a previous arterial blood gas draw on the right wrist. What should the nurse do first?

A. Check the blood count.
B. Apply pressure to the site.
C. Document the bleeding.
D. Monitor the bleeding.

Answer: B

Explanation:
If a client begins bleeding from the site of a previous arterial blood gas draw on the right wrist, the nurse should first apply pressure to the site. This prevents further bleeding. The remaining choices can be performed later.Reduction of Risk Potential

NEW QUESTION 305
- (Topic 6)
The highest incident of child abuse occurs in children in which age group?

A. birth–3 years old
B. 4–6 years old
C. 6–10 years old
D. more than 10 years old

Answer: A

Explanation:
Children between birth and 3 years of age have the highest rates of victimization (at 16 per 1,000 children).
Girls are slightly more likely to be victims than boys.Psychosocial Integrity

NEW QUESTION 310
- (Topic 6)
A nurse working in a pediatric clinic observes bruises on the body of a four year-old boy. The parents report the boy fell riding his bike. The bruises are located on his posterior chest wall and gluteal region. The nurse should:

A. Suggest a script for counseling for the family to the doctor on duty.
B. Recommend a warm bath for the boy to decrease healing time.
C. Notify the case manager in the clinic about possible child abuse concerns.
D. Recommend ROM to the patient??s spine to decrease healing time.

Answer: C

Explanation:
The patient??s safety should have the highest priority.

NEW QUESTION 314
- (Topic 6)
A patient that has TB can be taken off restrictions after which of the following parameters have been met?

A. Negative culture results.
B. After 30 days of isolation.
C. Normal body temperature for 48 hours.
D. Non-productive cough for 72 hours.

Answer: A

Explanation:
Negative culture results would indicate absence of infection.

NEW QUESTION 315
- (Topic 6)
A nurse is reviewing a patient??s ECG report. The patient exhibits a flat T wave, depressed ST segment and short QT interval. Which of the following medications can cause all of the above effects?

A. Morphine
B. Atropine
C. Procardia
D. Digitalis

Answer: D

Explanation:
Digitalis can cause all of the listed symptoms.

NEW QUESTION 317
- (Topic 6)
How many feet should separate the nurse and the source when extinguishing a small, wastebasket fire with an appropriate extinguisher?

A. 1 foot
B. 2 feet
C. 4 feet

D. 6 feet

Answer: D

Explanation:
The nurse should stand about 6 feet from the source of the fire. Getting closer might put the nurse in danger.Safety and Infection Control

NEW QUESTION 320
- (Topic 6)
A nurse gave medications to the wrong client. She stated the client responded to the name called. What is the nurse??s appropriate documentation?

A. Note in medication records the drug given
B. The client was not hurt, no need for documentation
C. Note the client??s orientation
D. Completely fill out an incident report

Answer: D

Explanation:
The incident report should always be filled out involving medication errors.

NEW QUESTION 325
- (Topic 6)
A nurse is trying to motivate a client toward more effective management of a therapeutic regimen. Which of the following actions by the nurse is most likely to be effective in increasing the client??s motivation?

A. determining whether the client has any family or friends living nearby
B. developing a lengthy discharge plan and reviewing it carefully with the client
C. teaching the client about the disorder at the client??s level of understanding
D. making a referral to an area agency for client followup

Answer: C

Explanation:
For maximum effectiveness, teach the client about the disorder at the client??s level of understanding.Health Promotion and Maintenance

NEW QUESTION 326
- (Topic 6)
A 32-year-old female frequently comes to her primary care provider with vague complaints of headache, abdominal pain, and trouble sleeping. In the past, the physician has dutifully prescribed medication, but little else. Which of the following comments by the nurse to the physician is appropriate?

A. ??Often women who are victims of domestic violence suffer vague symptoms such as abdominal pain.??
B. ??Often women become offended if asked about their safety in relationships.??
C. ??It is mandatory that all women be questioned about domestic violence.??
D. ??How would you feel to know that her partner is beating her and you didn??t ask???

Answer: A

Explanation:
There is a correlation between vague symptoms, such as abdominal pain, and battered syndrome. The astute clinician should question any woman who presents with suspicious symptoms such as these. Rarely are women offended by a properly worded question, such as, ??Do you feel safe in your present relationship??? Studies show an increase in case finding when such questions are asked. It is not mandatory that all women are assessed for violence, but it is prudent that allpersons new to a clinician be assessed by at least the one question noted previously. Castigating or shaming the physician typically does not improve client outcomes and might make for a difficult working environment for the nurse. Tactless comments, like the one in Choice 4, are not collegial and should be avoided.Psychosocial Integrity

NEW QUESTION 331
- (Topic 6)
A violation of a patient??s confidentiality occurs if two nurses are discussing client information in which of the following scenarios?

A. With a physical therapist treating the patient
B. With a social worker planning for discharge
C. With another nurse on duty to plan for break time
D. In the hallway outside the patient??s room.

Answer: D

Explanation:
Hallway discussions should not occur, because you do not who is listening, even though it may be a professional discussion.

NEW QUESTION 335
- (Topic 6)
A nurse is instructing a person who had a left CVA and right lower extremity hemiparesis to use a quad cane. Which of the following is the most appropriate gait sequence?

A. Place the cane in the patient??s left upper extremity, encourage cane, then right lowerextremity, then left upper extremity gait sequence.
B. Place the cane in the patient??s left upper extremity, encourage cane, then leftlower extremity, then right upper extremity gait sequence.

C. Place the cane in the patient??s right upperextremity, encourage cane, thenright lower extremity, then left upper extremity gait sequence.
D. Place the cane in the patient??s right upper extremity, encourage cane, thenleft lower extremity, then right upper extremity gait sequence.

Answer: A

Explanation:
The cane should be placed in the patient??s strong upper extremity, and left arm/right foot go together, for normal gait.

NEW QUESTION 338
- (Topic 6)
During a well-baby check of a 6-month-old infant, the nurse notes abrasions and petechaie of the palate. The nurse should:

A. inquire about foods the child is eating.
B. ask about the possibility of sexual abuse.
C. request to see the type of bottle used for feedings.
D. question the parent about objects the child plays with.

Answer: B

Explanation:
Generally oral sex leaves little physical evidence. Injury to the soft palate (such as bruising, abrasions, and petechaie) and pharyngeal gonorrhea are the only signs. Infants are at risk for sexual abuse.Psychosocial Integrity

NEW QUESTION 342
- (Topic 6)
A 26-year-old single woman is knocked down and robbed while walking her dog one evening. Three months later, she presents at the crisis clinic, stating that she cannot put this experience out of her mind. She complains of nightmares, extreme fear of being outside or alone, and difficulty eating and sleeping. What is the best response by the nurse?

A. ??I will ask the physician to prescribe medication for you.??
B. ??That must have been a very difficult and frightening experienc
C. It might be helpful to talk about it.??
D. ??In the future, you might walk your dog in a more populated area or hire someone else to take over this task.??
E. ??Have you thought of moving to a safer neighborhood???

Answer: B

Explanation:
Choice 2 gives the client support and an opportunity to discuss the experience. Choices 1, 3, and 4 do not validate her experience or permit discussion of her feelings.Psychosocial Integrity

NEW QUESTION 343
- (Topic 6)
A nurse is caring for a retired MD. The MD asks the question, ??What type of cells create exocrine secretions??? The correct answer is:

A. alpha cells
B. beta cells
C. acinar cells
D. plasma cells

Answer: C

Explanation:
Acinar cells create exocrine secretions.

NEW QUESTION 348
- (Topic 6)
A client reports that someone is in the room and trying to kill him. The nurse??s best response is:

A. ??No one is in your roo
B. Let??s get you more medicine.??
C. ??I do not see anyone, but you seem to be very frightened.??
D. ??No one can hurt you here.??
E. ??Just tell the person to go away.??

Answer: B

Explanation:
It is important to acknowledges the client??s fear. The other responses deny the client??s perceptions.
Psychosocial Integrity

NEW QUESTION 353
- (Topic 6)
A nurse is instructing a patient about the warning signs of (Digitalis) side effects. Which of the following side effects should the nurse tell the patient are sometimes associated with excessive levels of Digitalis?

A. Seizures

B. Muscle weakness
C. Depression
D. Anxiety

Answer: B

Explanation:
Palpitations and muscle weakness are found with excessive levels of Digitalis.

NEW QUESTION 358
- (Topic 6)
Which of the following substances need to be assessed when completing a family health assessment?

A. coffee, tea, cola, and cocoa
B. alcohol, tobacco, and illegal substances
C. medicines prescribed by a physician
D. all of the above

Answer: D

Explanation:
When assessing drug, alcohol, and tobacco practices among family members, a thorough investigation of prescribed, over-the-counter and illegal substance-use practices should be made. Assessment of dietary practices should include the amount and types of food the family eats; the social behaviors associated with dietary practices; and the meal planning, shopping, and preparation practices of the family.Health Promotion and Maintenance

NEW QUESTION 359
- (Topic 6)
A client is 36 hours post-op a TKR surgery. 270 cc??s of sero-sanguinous accumulates in the surgical drains. What action should the nurse take?

A. Notify the doctor
B. Empty the drain
C. Do nothing
D. Remove the drain

Answer: A

Explanation:
The physician should be notified if excessive drainage is noted from the surgical site.

NEW QUESTION 364
- (Topic 6)
A small amount of bubbling is seen in the water seal of a pleural drainage system when a client coughs. What should the nurse do?

A. Consider it a normal finding.
B. Check the system for leaks.
C. Clamp the chest tube.
D. Change the drainage system.

Answer: A

Explanation:
A small amount of bubbling is a normal finding in the water seal of a pleural drainage system when a client coughs. It is only a problem to find continuous, excessive bubbling in the waterseal, which indicates a leak.Reduction of Risk Potential

NEW QUESTION 366
- (Topic 6)
A 55 year-old female asks a nurse the following, ??Which mineral/vitamin is the most important to prevent progression of osteoporosis. The nurse should state:

A. Potassium
B. Magnesium
C. Calcium
D. Vitamin B12

Answer: C

Explanation:
Calcium is the most recognized osteoporosis treatment.

NEW QUESTION 367
- (Topic 6)
In hanging a parenteral IV fluid that is to be infused by gravity, rather than with an infusion pump, the nurse notes that the IV tubing is available in different drop factors. Which tubing is a microdrop set?

A. 15 drops per milliliter
B. 60 drops per milliliter
C. 20 drops per milliliter
D. 10 drops per milliliter

Answer: B

Explanation:
All microdrop sets are calculated to give 60 drops for each milliliter of IV fluid. Macrodrop sets are calculated to give 10, 15, or 20 drops for each milliliter of IV fluid.Pharmacological Therapies

NEW QUESTION 369
- (Topic 6)
A nurse notes that an elderly client suddenly does not keep appointments and is not wearing appropriate clothing. Which statement by the client raises the suspicion of financial abuse?

A. ??I am having difficulty paying for this new antibiotic the physician prescribed.??
B. ??I am a little short on cash since my daughter moved in to help me.??
C. ??I have not felt like shopping since the weather has gotten worse.??
D. ??People do not realize how difficult it is to make ends meet on a fixed income.??

Answer: B

Explanation:
Elderly clients on fixed incomes have difficulty meeting new expenses, such as medicine. Signs of financial abuse include unexplained illnesses that are left untreated, an inability to pay rent or purchase clothes and food, and inaccurate knowledge about finances. Financial abuse is a form of elder abuse and requires investigation.Psychosocial Integrity

NEW QUESTION 372
- (Topic 6)
Tricyclics (Antidepressants) sometimes have which of the following adverse affects on patients that have a diagnosis of depression?

A. Shortness of breath
B. Fainting
C. Large Intestine ulcers
D. Distal muscular weakness

Answer: B

Explanation:
Fainting and hypotension can be caused by Tricyclics.

NEW QUESTION 373
- (Topic 6)
Ten-year-old Jackie is admitted to the hospital with a medical diagnosis of Rheumatic Fever. She relates a history of ??a sore throat about a month ago.?? Bed rest with bathroom privileges is prescribed. Which of the following nursing assessments should be given the highest priority when assessing Jackie??s condition?

A. her response to being hospitalized
B. the presence of a macular rash on her trunk
C. her cardiac status
D. the presence of polyarthritis and pain in her joints

Answer: C

Explanation:
Monitoring cardiac status is of the highest priority. Permanent cardiac damage can result from rheumatic fever. The second priority is assessing the client??s joints for the presence of polyarthritis and accompanying pain.Physiological Adaptation

NEW QUESTION 376
- (Topic 6)
A client diagnosed with Borderline Personality Disorder frequently attempts to burn herself. The best intervention to facilitate behavior change is:

A. constantly observing the client to prevent self-harm.
B. enlisting the client in defining and describing harmful behaviors.
C. checking on the client every 15 minutes to ensure she is not engaging in harmful behavior.
D. removing all items from the environment that the client could use to harm herself.

Answer: B

Explanation:
The challenge when intervening with clients who might harm themselves is to maintain client safety while facilitating behavior change. Enlisting the client to identify the triggers for self-harm makes the client an active participant in treatment. Nurses are less judgmental when they understand the source of the behavior and can be sensitive to client feelings. Psychosocial Integrity

NEW QUESTION 380
- (Topic 6)
To manage time most effectively, the nurse responds to which of the following stimuli first:

A. the physician??s loud verbal direction.
B. the nursing supervisor who is going to a meeting.
C. unit staff leaving on a break.
D. the care needs of the returning postoperative client just exiting the elevator.

Answer: D

Explanation:
While many environmental stimuli might compete for attention and time, the client care needs of complex or unstable clients and those requiring assessment and care must take priority.Coordinated Care

NEW QUESTION 381
- (Topic 6)
A patient is scheduled for electro-convulsive therapy treatment scheduled in the morning. What must the evening nurse do to provide the client ECT treatment possible?

A. Patient signs an informed consent form
B. Patient is given morning medications
C. Patient gets a good night??s sleep
D. Patient has a good breakfast

Answer: A

Explanation:
An informed consent is required prior to surgery.

NEW QUESTION 384
- (Topic 6)
A client is taking the fluoroquinolone Ciprofloxin for acute prostatitis. After a few doses of the agent, he develops severe muscle pain. The most likely cause of the adverse reaction is:

A. electrolyte imbalance.
B. impending tendon rupture.
C. calcium deposits.
D. antibiotic-associated colitis.

Answer: B

Explanation:
An untoward, adverse drug reaction associated with the quinolones is tendon rupture. Electrolyte imbalance has not been associated with the group, and antibiotic-associated colitis is most common in augmentin and penicillin groups.Safety and Infection Control

NEW QUESTION 389
- (Topic 6)
A nurse has been ordered to set-up Buck??s traction on a patient??s lower extremity due to a femur fracture. Which of the following applies to Buck??s traction?

A. A weight greater than 10 lb
B. should be used.
C. The line of pull is upward at an angle.
D. The line of pull is straight
E. A weight greater than 20 lb
F. should be used.

Answer: C

Explanation:
A straight line of pull is indicated with Buck??s traction.

NEW QUESTION 392
- (Topic 6)
A two-year old has been in the hospital for 3 weeks and seldom seen family members due to isolation precautions. Which of the following hospitalization changes is most like to be occurring?

A. Guilt
B. Trust
C. Separation anxiety
D. Shame

Answer: C

Explanation:
Separation anxiety can easily occur after six months during hospitalization.

NEW QUESTION 394
- (Topic 6)
A nurse is reviewing a patient??s medical record. The record indicates the patient has limited shoulder flexion on the left. Which plane of movement is limited?

A. Horizontal
B. Sagittal
C. Frontal
D. Vertical

Answer: B

Explanation:
Sagittal motion occurs in the midline plane of the body.

NEW QUESTION 397
- (Topic 6)
A nurse is screening patients for immunizations. Which of following is not a contraindication for immunization?

A. Seizures
B. Fever > 3 days
C. Malignancy >3 months
D. Illness >6 months

Answer: D

Explanation:
Chronic conditions are not considered a contraindication for immunization.

NEW QUESTION 401
- (Topic 6)
A thirty-seven year-old female in room 307 has a diagnosis of acquired immune deficiency syndrome (AIDS). Which of the following situations requires nurse intervention?

A. A certified nursing assistant states, ??The patient in 307 is not wearing glovesshaving her legs.??
B. A nursing assistant at the nursing station states, ??The patient in 307 has arespiratory rate of 16.??
C. A nursing student in the cafeteria states, ??Dr.Jones told the patient in room307 that she was going to die.??
D. A certified nursing assistant states, ??D
E. Jones hasn??t made rounds thismorning.??

Answer: C

Explanation:
Patient confidentiality should be observed, especially in public places. The nurse should tell the nursing student do not discuss confidential information in public.

NEW QUESTION 405
- (Topic 6)
An adult who had been abused as a child is discussing the group therapy program. Which statement indicates that the client has gained insight?

A. ??I think I was a lonely child because I could not tell anyone about my abuse.??
B. ??I am now aware of how deep-seated my anger i
C. Before I did not realize I was angry.??
D. ??The program has given me the courage to tell my mother how I felt about her role in my hurt.??
E. ??There are so many people just like me, who are just normal people that had bad things happen to them.??

Answer: B

Explanation:
Children who are abused learn to cope with the painful experiences by ignoring painful feelings and avoiding getting close to people. As adults, victims of abuse usually continue to repress feelings, avoid close interpersonal relationships, and frequently use alcohol or drugs to block painful memories. Long-term effects in adults might include criminal/violent behavior (for adult males), substance abuse, and a variety of social and emotional problems (including suicidal thoughts, anxiety, hostility, dissociation, and interpersonal difficulties).Psychosocial Integrity

NEW QUESTION 410
- (Topic 6)
Signs of internal bleeding include all of the following except:

A. painful or swollen extremities.
B. a tender, rigid abdomen.
C. vomiting bile.
D. bruising.

Answer: C

Explanation:
Vomiting bile is usually not a sign of internal bleeding. Signs of internal bleeding include painful or swollen extremities; a tender, rigid abdomen; and bruising.Safety and Infection Control

NEW QUESTION 413
- (Topic 6)
Which of the following arterial blood gas values indicates a patient may be experiencing a condition of metabolic acidosis?

A. PaO2 (90%)
B. Bicarbonate 159
C. CO(2) 47 mm Hg
D. pH 7.34

Answer: B

Explanation:
The bicarbonate value is below normal, indicating a condition of metabolic acidosis.

NEW QUESTION 415
- (Topic 6)
A nurse is assigned to do pre-operative teaching on a blind patient who is scheduled for surgery the following morning. What teaching strategy would best fit the situation?

A. Verbal teaching in short sessions throughout the day
B. Pre-operative booklet on the surgery in Braille
C. Provide a tape for the client
D. Have the blind patient??s family member instruct the patient.

Answer: A

Explanation:
Information is smaller amounts is easier to retain. Teaching the day before the procedure is best accomplished in a one on one format.

NEW QUESTION 417
- (Topic 6)
A 32 year-old male with a complaint of dizziness has an order for Morphine via. IV. The nurse should do which of the following first?

A. Check the patient??s chest x-ray results.
B. Retake vitals including blood pressure.
C. Perform a neurological screen on the patient.
D. Request the physician on-call assess the patient.

Answer: B

Explanation:
Dizziness can be a sign of hypotension, that may a contraindication with Morphine.

NEW QUESTION 420
- (Topic 6)
A gastroenterologist should be consulted for clients suffering from:

A. digestive system diseases.
B. urinary system diseases.
C. female reproductive system diseases.
D. nervous system diseases.

Answer: A

Explanation:
A gastroenterologist cares for clients with digestive system diseases. A urologist cares for clients with urinary system diseases. A gynecologist cares for clients with female reproductive system diseases. A neurologist cares for clients with nervous system diseases.Coordinated Care

NEW QUESTION 423
- (Topic 6)
An advance directive is written and notarized according to law in the state of Colorado. This document is legal and binding:

A. internationally.
B. in the state of Colorado only.
C. in the continental United States.
D. in the county of origination only.

Answer: B

Explanation:
Choices 1, 3, and 4 are incorrect. Advance directive protocols and documents are defined by each state.
Coordinated Care

NEW QUESTION 424
- (Topic 6)
A client has a 10% dextrose in water IV solution running. He is scheduled to receive his antiepileptic drug, phenytoin (Dilantin), at this time. The nurse knows that the phenytoin:

A. is given after the D10W is finished.
B. should be given at the time it is due in the medication port closest to the client.
C. can be piggybacked into the D10W solution now.
D. is incompatible with dextrose solutions.

Answer: D

Explanation:

Phenytoin and dextrose will precipitate. Normal saline is used to flush before andafter phenytoin administration.The administration of an antiepileptic drug cannot be delayed to maintain a therapeutic blood level.Pharmacological Therapies

NEW QUESTION 425
- (Topic 6)
A nurse is caring for a patient in the step down unit. The patient has signs of increased intracranial pressure. Which of the following is not a sign of increased intracranial pressure?

A. Bradycardia
B. Increased pupil size bilaterally
C. Change in LOC
D. Vomiting

Answer: B

Explanation:
Unilateral pupil changes indicate changes in ICP.

NEW QUESTION 426
- (Topic 6)
A nurse is reviewing a patient??s current Lithium levels. Which of the following values is outside the therapeutic range?

A. 1.0 mEq/L
B. 1.1 mEq/L
C. 1.2 mEq/L
D. 1.3 mEq/L

Answer: D

Explanation:
* 1.0-1.2 mEq/L is considered standard therapeutic range for patient care.

NEW QUESTION 428
- (Topic 6)
When a client describes their family as having multiple wives, all of whom are sisters, married to one man, the nurse documents the family structure as?

A. polyandry
B. soronal
C. nonsororal
D. sororate

Answer: B

Explanation:
The practice of polygamy refers to having multiple wives or husbands. When there are multiple wives who are sisters, the polygamy is designated as soronal. When the wives are not sisters it is nonsororal. Polyandry refers to multiple husbands and is rare. Some cultures practice a polygamy designated as sororate. Sororate polygamy specifies that a husband must marry his wife??s sister if she dies. These marriages are successive rather than concurrent.Health Promotion and Maintenance

NEW QUESTION 432
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