unrelated to the memory loss of Alzheimer's disease. The client cannot stop reminiscing at will.

CN: Psychosocial integrity; CL: Apply

102. 3. The best rationale for day treatment for the client with Alzheimer's disease is the enhancement of social interactions. More daily structure, excellent staff, and allowing caregivers more time for themselves are all positive aspects, but they are less focused on the client's needs.

CN: Psychosocial integrity; CL: Apply

103. 1. Considerable assistance is associated with moderate impairment when the client cannot make decisions but can follow directions. Managing medications is needed even in mild impairment. Constant care is needed in the terminal phase, when the client cannot follow directions. Supervision of shaving is appropriate with mild impairment—that is, when the client still has motor function but lacks judgment about safety issues.

CN: Psychosocial integrity; CL: Synthesize

104. 2, 4, 5. Motion and sound detectors, a Medical Alert bracelet, and door alarms are all appropriate interventions for wandering. Sleep medications do not prevent wandering before and after the client is asleep and may have negative effects. Having a relative sit with the client is usually an unrealistic burden.

CN: Psychosocial integrity; CL: Synthesize

105. 2. Because the client is experiencing difficulty processing and completing complex tasks, the priority is to provide the client with only one step at a time, thereby breaking the task up into simple steps, ones that the client can process. Repeating the directions until the client follows them or demonstrating how to do the task is still too overwhelming to the client because of the multiple steps involved. Although maintaining structure and routine is important, it is unrelated to task completion.

CN: Psychosocial integrity; CL: Synthesize

106. 3. The nurse needs to present reality without arguing with the delusions. Therefore, stating that the client is in the hospital and the nurses are trying to help is most appropriate. The client doesn't recognize the delusion or why it exists. Telling the client that the staff likes him too much to want to kill him is inappropriate because the client believes the delusions and doesn't know that they are false beliefs. It also restates the word, kill, which may reinforce the client's delusions. Telling the client not to be silly is condescending and disparaging and therefore inappropriate.

CN: Psychosocial integrity; CL: Synthesize

107. 1. The vulgar or sexual behaviors are commonly expressions of anger or more sensual needs that can be addressed directly. Therefore, the families should be encouraged to ignore the behaviors but attempt to identify their purpose. Then the purpose can be addressed, possibly leading to a decrease in the behaviors. Because of impaired cognitive function, the client is not likely to be able to process the inappropriateness of the behaviors if given feedback. Likewise, anger management strategies would be ineffective because the client would probably be unable to process the inappropriateness of the behaviors. Risperidone (Risperdal) may decrease agitation, but it does not improve social behaviors.

CN: Psychosocial integrity; CL: Apply

108. 4. The statement about expecting that the old Dad would be back conveys a lack of acceptance of the irreversible nature of the disease. The statement about not realizing that the deterioration would be so incapacitating is based in reality. The statement about the Alzheimer's group is based in reality and demonstrates the son's involvement with managing the disease. Stating that reminiscing is important reflects a realistic interpretation on the son's part.

CN: Psychosocial integrity; CL: Evaluate

109. 1. When compared with other similar medications, donepezil (Aricept) has fewer adverse effects. Donepezil is effective primarily in the early stages of the disease. The drug helps to slow the progression of the disease if started in the early stages. After the client has been diagnosed for 6 years, improvement to the level seen 6 years ago is highly unlikely. Data are not available to support the drug's effectiveness for clients in the terminal phase of the disease.

CN: Pharmacological and parenteral therapies; CL: Apply

110. 3. Antipsychotics are most effective with agitation and assaultiveness. Antipsychotics have little effect on sleep disturbances, concomitant depression, or confusion and withdrawal.

CN: Pharmacological and parenteral therapies; CL: Apply

111. 1. Although all of the side effects listed are possible with Ativan, paradoxical excitement is cause for immediate discontinuation of the medication. (Paradoxical excitement is the opposite reaction to Ativan than is expected.) The other side effects tend to be minor and usually are transient.

CN: Pharmacology and parental therapies; CL: Apply

112. 4. Change increases stress. Therefore, the most important and relevant suggestion is to maintain consistency in the client's environment, routine, and caregivers. Although rest periods are important, going to bed interferes with the sleep-wake cycle. Rest in a recliner chair is more useful. Testing cognitive functioning and reality orientation are not likely to be successful and may increase stress if memory loss is severe.

 CN: Psychosocial integrity; CL: Apply

Managing Care Quality and Safety

113. 4. The neighbor could be harmed as well as the daughter if she should try to stop her father from using the gun, so both should be notified. Any use of firearms against another person requires the involvement of the police. The nurse has a legal/ethical responsibility to warn potential victims and other involved parties as well as law enforcement authorities when one person makes a threat against another person. This duty supersedes confidentiality statutes. Failure to do so and to document it can result in civil penalties. The client's early dementia would likely not prevent him from carrying through his threat.

 CN: Management of Care; CL: Analyze

114. 4. Cogentin has a common side effect of blurred vision. After evaluating the relative doses of Haldol and Cogentin, the *assessment* would be that the higher dose of Cogentin compared to the dose of Haldol is responsible for the blurred vision. (High doses of Haldol can cause blurred vision at times.) Reporting that Mr. Roberts has blurred vision is the *situation*. Listing the medications and doses is describing the *background*. The *recommendation* would be a lower dose of Cogentin.

 CN: Management of care; CL: Synthesize

115. 1, 3. Without a sufficient range and quantity of services, care is inadequate and hospitalization rates increase. Nonshifting of allocated funding to outpatient services has increased the problem with the range and quantity of services. Reserving hospitalization for emergency services was a practice before managed care. The principle of “least restrictive alternative” is still as relevant as it was before managed care. There are not enough group homes available.

 CN: Management of care; CL: Apply

116. 4. The client exhibits aggression against his perceived adversary when he names another client as his adversary. The staff will need to watch him carefully for signs of impending violent behavior that may injure others. Crying about a divorce would be appropriate, not pathologic, behavior demonstrating

grief over a loss. A petition to delay bedtime would be a positive, direct action aimed at a bothersome situation. Although declining to attend group therapy needs follow-up, there may be any number of unknown reasons for this action.

 CN: Safety and infection control; CL: Synthesize

117. 2. When caring for a client with cognitive impairment, the priority is to ensure that all objects in the client's path are removed to prevent the client from falling. Additional measures, such as having two people accompany the client when he ambulates, placing his favorite things in safekeeping, and giving medications in a liquid form to be sure he swallows them, are less crucial and available.

 CN: Safety and infection control; CL: Synthesize

118. 1. The most common reason for the nurse's discomfort with elderly clients is that she has not examined her own fears and conflicts about aging. Until nurses resolve their fears, it is unlikely that they will feel comfortable with elderly clients. A dislike of physical contact with older people, a desire to be surrounded by beauty and youth, and recent experiences with a parent's elderly friends are possible explanations, but not common or likely.

 CN: Management of care; CL: Analyze

TEST 3: Personality Disorders, Substance-Related Disorders, Anxiety Disorders, and Anxiety-Related Disorders

The Client with a Personality Disorder

1. A client has been diagnosed with Avoidant Personality Disorder. He reports loneliness, but has fears about making friends. He also reports anxiety about being rejected by others. In designing a long-term treatment plan, in what order, from first to last, should the nurse include the following?

1. Teach the client anxiety management and social skills.
2. Ask the client to join one of his chosen activities with the nurse and two other clients.
3. Talk with the client about his self-esteem and his fears.
4. Help the client make a list of small group activities at the center he would find interesting.

2. A client diagnosed with borderline personality disorder has self-inflicted cuts on her arms. The nurse is assessing the client for the risk of suicide. What should the nurse ask the client **first**?

☐ **1.** About medications she has taken recently.
☐ **2.** If she is taking antidepressants.
If she has a suicide plan.
☐ **4.** Why she cut herself.

3. When developing the plan of care for a client diagnosed with a personality disorder, the nurse plans to assist the client primarily with which of the following?

Specific dysfunctional behaviors.
☐ **2.** Psychopharmacologic compliance.
☐ **3.** Examination of developmental conflicts.
☐ **4.** Manipulation of the environment.

4. A client diagnosed with paranoid personality disorder is hospitalized for physically threatening his wife because he suspects her of having an affair with a coworker. Which of the following approaches should the nurse employ with this client?
☐ **1.** Authoritarian.
☐ **2.** Parental.
Matter-of-fact.
☐ **4.** Controlling.

5. When planning care for a client diagnosed with schizotypal personality disorder, which of the following helps the client become involved with others?
☐ **1.** Participating solely in group activities.
☐ **2.** Being involved with primarily one-to-one activities.
☐ **3.** Leading a sing-along in the afternoon.
Attending an activity with the nurse.

6. A client is complaining to other clients about not being allowed by staff to keep food in her room. The nurse should:
☐ **1.** Ignore the client's behavior.
Set limits on the behavior.
☐ **3.** Reprimand the client.
☐ **4.** Allow the snack to be kept in her room.

7. A client with an Axis II diagnosis of antisocial personality disorder has a potential for violence and aggressive behavior. Which of the following client outcomes to be accomplished in the short term is **most** appropriate for the nurse to include in the plan of care?
☐ **1.** Use humor when expressing anger.
Discuss feelings of anger with staff.
☐ **3.** Ask the nurse for medication when upset.
☐ **4.** Use indirect behaviors to express anger.

8. A new client on the psychiatric unit has been diagnosed with depression and obsessive-compulsive personality disorder (OCPD). During visiting hours, her husband states to the nurse that he doesn't understand this OCPD and what can be done about it. What information should the nurse share with the client and her husband? Select all that apply.
Perfectionism and overemphasis on tasks usually interfere with friendships and

leisure time.

☐ **2.** It will help to interrupt her tasks and tell her you are going out for the evening.

There are medicines, such as clomipramine (Anafranil) or fluoxetine (Prozac) that may help.

Remind your wife that it is “OK” to be human and make mistakes.

☐ **5.** Reinforce with her that she is not allowed to expect the whole family to be perfect too.

This disorder typically involves inflexibility and a need to be in control.

9. A client diagnosed with paranoid personality disorder is being admitted on an Immediate Detention Order (24-hour hold) after a physical altercation with a police officer who was investigating the client's threatening phone calls to his neighbors. He states that his neighbors are spying on him for the government. “I want them to stop and leave me alone. Now they have you nurses and doctors involved in their conspiracy.” Which of the following nursing approaches are most appropriate? Select all that apply.

Approach the client in a professional, matter-of-fact manner.

Avoid intrusiveness in interactions with the client.

☐ **3.** Gently present reality to counteract the client's current paranoid beliefs.

Develop trust consistently with the client.

Do not pressure the client to attend any groups.

10. A 28-year-old client with an Axis I diagnosis of major depression and an Axis II diagnosis of dependent personality disorder has been living at home with very supportive parents. The client is thinking about independent living on the recommendation of the treatment team. The client states to the nurse, “I don't know if I can make it in an apartment without my parents.” The nurse should respond by saying to the client:

☐ **1.** “You're a 28-year-old adult now, not a child who needs to be cared for.”

☐ **2.** “Your parents won't be around forever. After all, they are getting older.”

☐ **3.** “Your parents need a break, and you need a break from them.”

“Your parents have been supportive and will continue to be even if you live apart.”

11. A client moves in with her family after her boyfriend of 4 weeks told her to leave. She is admitted to the subacute unit after reporting feeling empty and lonely, being unable to sleep, and eating very little for the last week. Her arms are scarred from frequent self-mutilation. The nurse should do which of the following from first to last?

1. Monitor for suicide and self-mutilation.

2. Discuss the issues of loneliness and emptiness.

3. Monitor sleeping and eating behaviors.

4. Discuss her housing options for after discharge.

12. The client approaches various staff with numerous requests and needs to the point of disrupting the staff's work with other clients. The nurse meets with the staff to decide on a consistent, therapeutic approach for this client. Which of the following approaches will be most effective?

☐ **1.** Telling the client to stay in his room until staff approach him.
☐ **2.** Limiting the client to the dayroom and dining area.
☐ **3.** Giving the client a list of permissible requests.
Having the client address needs to the staff person assigned.

13. The client with diagnosed borderline personality disorder tells the nurse, "You're the best nurse here. I can talk to you and you listen. You're the only one here that can help me." Which of the following responses by the nurse is **most** therapeutic?

☐ **1.** "Thank you; you're a good person."
"All of the nurses here provide good care."
☐ **3.** "Other clients have told me that too."
☐ **4.** "Mary and Sam are good nurses too."

14. The client diagnosed with borderline personality disorder is admitted to the unit after having attempted to cut her wrists with a pair of scissors. The client has several scars on both arms from self-mutilation and suicide gestures. A staff member states to the nurse, "It's just attention that she wants, she's not going to kill herself." The nurse should respond to the staff member by saying:

☐ **1.** “She's here now and we have to do our best.”
☐ **2.** “She needs to be here until she can control her behavior.”
☐ **3.** “I'm ashamed of you; you know better than to say that.”
“Any attempt at self-harm is serious, and safety is a priority.”

15. The nurse assesses a client to be at risk for self-mutilation and implements a safety contract with the client. Which of the following client behaviors indicate that the contract is working?
☐ **1.** The client withdraws to his room when feeling overwhelmed.
The client notifies staff when anxiety is increasing.
☐ **3.** The client suppresses his feelings when angry.
☐ **4.** The client displaces his feelings onto the primary health care provider.

16. The client diagnosed with borderline personality disorder who is to be discharged soon threatens to “do something” to herself if discharged. The nurse should **first:**
☐ **1.** Request that the client's discharge be canceled.
☐ **2.** Ignore the client's statement because it's a sign of manipulation.
☐ **3.** Ask a family member to stay with the client at home temporarily.
Discuss the meaning of the client's statement with her.

17. A 19-year-old client is admitted to a psychiatric unit with an Axis I diagnosis of alcohol abuse and an Axis II diagnosis of personality disorder not otherwise specified. The client's mother states, “He's always in trouble, just like when he was a boy. Now he's just a bigger prankster and out of control.” In view of the client's history, which of the following is **most** important initially?
☐ **1.** Letting the client know the staff has the authority to subdue him if he gets unruly.
☐ **2.** Keeping the client isolated from other clients until he is better known by the staff.
☐ **3.** Emphasizing to the client that he will have to pay for any damage he causes.
Closely observing the client's behavior to establish a baseline pattern of functioning.

18. The client tells the nurse at the outpatient clinic that she doesn't need to attend groups because she's “not a regular like these other people here.” The nurse should respond to the client by saying:
☐ **1.** “Because you're not a regular client, sit in the hall when the others are in group.”
☐ **2.** “Your family wants you to attend, and they will be very disappointed if you don't.”

☐ **3.** “I'll have to mark you absent from the clinic today and speak to the doctor about it.”

“You say you're not a regular here, but you're experiencing what others are experiencing.”

19. The client who has a history of using angry outbursts when frustrated begins to curse at the nurse during an appointment after being informed that she will have to wait to have her medication refilled. Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “You're being very childish.”

☐ **2.** “I'm sorry if you can't wait.”

“I will not continue to talk with you if you curse.”

☐ **4.** “Come back tomorrow and your medication will be ready.”

20. Which of the following behaviors indicates to the nurse that the client diagnosed with avoidant personality disorder is improving?

Interacting with two other clients.

☐ **2.** Listening to music with headphones.

☐ **3.** Sitting at a table and painting.

☐ **4.** Talking on the telephone.

21. One evening the client takes the nurse aside and whispers, “Don't tell anybody, but I'm going to call in a bomb threat to this hospital tonight.” Which of the following actions is the priority?

☐ **1.** Warning the client that his telephone privileges will be taken away if he abuses them.

☐ **2.** Offering to disregard the client's plan if he does not go through with it.

☐ **3.** Notifying the proper authorities after saying nothing until the client has actually completed the call.

Explaining to the client that this information will have to be shared immediately with the staff and the primary health care provider.

22. When teaching a nursing assistant new to the unit about the principles for the care of a client diagnosed with a personality disorder, the nurse should explain that:

The clients are accepted although their behavior may not be.

☐ **2.** Clients need limits on their behavior.

☐ **3.** The staff members are the primary ones left to care about these clients.

☐ **4.** The staff should use minimal humor when working with these clients.

23. The nurse is talking with a client who has been diagnosed with antisocial personality disorder about how to socialize during activities without being seductive. The nurse should focus the discussion on which of the following

areas?

Explaining the negative reactions of others toward his behavior.

☐ **2.** Suggesting he apologize to others for his behavior.

☐ **3.** Asking him to explain the reasons for his seductive behavior.

☐ **4.** Discussing his relationship with his mother.

24. Which of the following approaches is most appropriate to use with a client diagnosed with a narcissistic personality disorder when discrepancies exist between what the client states and what actually exists?

☐ **1.** Limit setting.

Supportive confrontation.

☐ **3.** Consistency.

☐ **4.** Rationalization.

25. The client with histrionic personality disorder is melodramatic and responds to others and situations in an exaggerated manner. The nurse should recommend which of the following activities for this client?

☐ **1.** Party planning.

☐ **2.** Music group.

☐ **3.** Cooking class.

Role-playing.

The Client with an Alcohol-Related Disorder

26. A client has been diagnosed with dementia related to chronic and heavy alcohol consumption. In a family meeting with the client, discharge plans are being discussed. Which of the following points should the nurse share with the family and client? Select all that apply.

☐ **1.** The house and garage need to be searched and all the alcohol products destroyed.

☐ **2.** Without continued alcohol intake, the client will gradually get better.

☐ **3.** With the memory loss, answer the client's question once, and then ignore that question when asked again.

Safety alarms on the doors will help to keep the client from wandering off.

As the need for supervision increases, it may be necessary for the client to be placed in an extended care facility.

27. In an outpatient addictions group, a recovering client said that before her treatment, her husband drank on social occasions. “Now he drinks at home, from the time he comes home from work until he goes to bed. He says that he doesn't like me anymore and that I expect him to do more work on the house and yard. I use to ignore that stuff. I don't know what to do.” The nurse would make the following comments in which order of priority from first to last?

1. “What do you think you could do to have your husband come in for an evaluation?”
2. “I hear how confused and frustrated you are.”
3. “It can happen that as one person sobers up, the spouse deteriorates.”
4. “What have you tried to do about your husband's behaviors?”

28. For the client who has difficulty falling asleep at night because of withdrawal symptoms from alcohol, which are abating, which of the following nursing interventions is likely to be **most** effective?

☐ **1.** Inviting the client to play a board game with the nurse.

☐ **2.** Allowing the client to sit in the community room until the client feels sleepy.

☐ **3.** Advising the client to sleep on the sofa in the dayroom.

Teaching the client relaxation exercises to use before bedtime.

29. A client known to have alcohol dependence is admitted to the emergency department with a temperature of 99°F (37.2°C), a pulse of 110, respirations of 26, and blood pressure of 150/98. The blood alcohol level is 0.25%, three times the legal limit. Now the client is becoming belligerent and uncooperative. In which order from first to last should the following nursing and medical prescriptions be implemented?

1. Administer lorazepam 2 mg IM.

2. Draw blood for a magnesium level.

3. Take vital signs every 15 minutes.

4. Place the client in a quiet room with dimmed lights.

30. A client has been admitted to the emergency department with alcohol withdrawal delirium. The nurse is assessing the client for signs of withdrawal. At 9 AM on 10/25, the nurse notes that the client is confused. Vital signs are T =

99°F (37.2°C), P = 50, R = 10, and BP = 100/60. The nurse compares these findings to the nurses' progress notes from admission 24 hours ago (see below). What should the nurse do **first**?

Contact the primary health care provider.

☐ **2.** Increase the rate of the IV infusion.

☐ **3.** Attempt to arouse the client.

☐ **4.** Administer magnesium sulfate.

Progress Notes

Date	Time	Progress Notes
10/24/13	09:00 PM	T = 99° F (37.2°C); P = 110; R = 18; BP = 140/90; Client has IV D_5W keep open rate started; diazepam administered as prescribed. Client oriented x 3.
10/25/13	01:00 AM	T = 99.2° F (37.3°C); P = 90; R = 14; BP = 130/80; Client resting.
10/25/13	05:00 AM	T = 99° F (37.2°C); P = 70; R = 14; BP = 126/80; Client oriented x 3.

31. An intoxicated client is admitted to the hospital for alcohol withdrawal. Which of the following should the nurse do to help the client become sober?

☐ **1.** Give the client black coffee to drink.

☐ **2.** Walk the client around the unit.

☐ **3.** Have the client take a cold shower.

Provide the client with a quiet room to sleep in.

32. The client is admitted to the hospital for alcohol detoxification. Which of the following interventions should the nurse use? Select all that apply.

Taking vital signs.

Monitoring intake and output.

☐ **3.** Placing the client in restraints as a safety measure.

Reinforcing reality if the client is disoriented or hallucinating.

Explaining to the client that the symptoms of withdrawal are temporary.

33. The nurse is assessing a client who has fallen twice in the last 2 days. The client has been diagnosed with delirium tremens (DTs) following withdrawal from alcohol use. The nurse should further evaluate the client for

which of the following? Select all that apply.

Disorientation.

☐ **2.** Paralysis.

Elevated temperature.

Diaphoresis.

Visual or auditory hallucinations.

34. A client was discharged from an alcohol rehabilitation program on clonazepam 0.5 mg three times a day. Several months later he reports having insomnia, shakiness, sweating, and one seizure. The nurse should **first** ask the client if he:

☐ **1.** Has been drinking alcohol with the clonazepam.

☐ **2.** Has developed tolerance to the clonazepam and needs to increase the dose.

Has stopped taking the clonazepam suddenly.

☐ **4.** Is having a panic attack and needs to take an extra clonazepam.

35. A client is entering the chemical dependency unit for treatment of alcohol dependency. Which of the client's possessions should the nurse place in a locked area?

☐ **1.** Toothpaste.

☐ **2.** Dental floss.

☐ **3.** Shaving cream.

Antiseptic mouthwash.

36. A client is entering rehabilitation for alcohol dependency as an alternative to going to jail for multiple DUIs (driving under the influence). While obtaining the client's history, the nurse asks about the amount of alcohol he consumes daily. He responds, “I just have a few drinks with the guys after work.” Which of the following responses by the nurse is **mos**t therapeutic?

☐ **1.** “That's what all the clients here say at first.”

☐ **2.** “Then you should have had a designated driver for yourself.”

☐ **3.** “I guess you just can't handle a few drinks.”

“You say you have a few drinks, but you have multiple arrests.”

37. While admitting a client to the alcohol treatment program, the nurse asks the client how long she's been drinking, how much she's been drinking, and when she had her last drink. The client replies that she has been drinking about a liter of vodka a day for the past week and her last drink was about an hour ago. This information helps the nurse to determine which of the following?

☐ **1.** The severity of the disease.

The severity of withdrawal symptoms.

☐ **3.** The possibility of alcoholic hallucinosis.
☐ **4.** The occurrence of delirium tremens.

38. A client who is experiencing alcohol withdrawal exhibits tremors, diaphoresis, and hyperactivity. Blood pressure is 190/87 mm Hg and pulse is 92 bpm. Which of the following medications should the nurse expect to administer?
☐ **1.** Haloperidol (Haldol).
Lorazepam (Ativan).
☐ **3.** Benztropine (Cogentin).
☐ **4.** Naloxone (Narcan).

39. Which of the following assessments provides the best information about the client's physiologic response and the effectiveness of the medication prescribed specifically for alcohol withdrawal?
☐ **1.** Nutritional status.
☐ **2.** Evidence of tremors.
Vital signs.
☐ **4.** Sleep pattern.

40. A client who had been drinking heavily over the weekend could not remember specific events of where he had been or what he had done. The nurse interprets this information as indicating that the client experienced which of the following conditions?
Blackout.
☐ **2.** Hangover.
☐ **3.** Tolerance.
☐ **4.** Delirium tremens.

41. A client is entering the alcohol treatment program for the fourth time in 5 years. Which of the following statements by the nurse will be **most** helpful to the client?
☐ **1.** “I hope you are serious about maintaining your sobriety this time.”
☐ **2.** “I'm Maria, a nurse here. I don't know you from past attempts, but you'll get it right this time.”
☐ **3.** “I know someone who was successful after the fifth program.”
“I'm Maria, a nurse in the program. The staff and I will help you through the program.”

42. The wife of a client with alcohol dependency tells the nurse, “I'm tired of making excuses for him to his boss and coworkers when he can't make it into work. I believe him every time he says he's going to quit.” The nurse recognizes the wife's statement as indicating which of the following behaviors?
☐ **1.** Helpfulness.

☐ **2.** Self-defeat.
Enabling.
☐ **4.** Masochism.

43. Which of the following statements by the nurse participating in a group confrontation of a coworker is **most** helpful in reducing the coworker's denial about alcohol being a problem?
☐ **1.** “Your behavior is unprofessional.”
☐ **2.** “As a nurse, you should have sought help earlier.”
☐ **3.** “Nurses are the worst when it comes to asking for help.”
“You have alcohol on your breath.”

44. The husband of a nurse who is being confronted by a group about her problem with alcohol asks the nurse acting as the group leader what he should say to his wife during the meeting. The nurse leader directs the husband to use which of the following statements to facilitate his wife's entrance into treatment?
☐ **1.** “The children and I want you to get help.”
☐ **2.** “If your parents were alive, they would be extremely disappointed in you.”
“Either you get help or the kids and I will move out of the house.”
☐ **4.** “You need to enter treatment now or be a drunk if that's what you want.”

45. A nurse working in an alcohol rehabilitation program is teaching staff how to give clients constructive feedback. Which of the following statements given as an example illustrates that the staff member understands the nurse's teaching regarding the use of constructive feedback?
☐ **1.** “I think you're a real con artist.”
☐ **2.** “You're dominating the conversation.”
“You interrupted Terry twice in 4 minutes.”
☐ **4.** “You don't give anyone a chance to finish talking.”

46. A client ashamedly tells the nurse that he hit his wife while intoxicated and asks the nurse if his wife will ever forgive him. The nurse should reply to the client by saying:
☐ **1.** “Perhaps you could ask her and find out.”
☐ **2.** “That's something you can explore in family therapy.”
☐ **3.** “It would depend on how much she really cares for you.”
“You seem to have some feelings about hitting your wife.”

47. While meeting with the nurse, a client's wife states, “I don't know what else to do to make him stop drinking.” The nurse should refer the wife to which of the following organizations?
☐ **1.** Alateen.

Al-Anon.
☐ **3.** Employee assistance program.
☐ **4.** Alcoholics Anonymous.

48. Which of the following nursing actions is contraindicated for the client who is experiencing severe symptoms of alcohol withdrawal?
Helping the client walk.
☐ **2.** Monitoring intake and output.
☐ **3.** Assessing vital signs.
☐ **4.** Using short, concrete statements.

49. Which of the following client statements indicates to the nurse that the client needs further teaching about disulfiram (Antabuse)?
"I can drink one or two beers and not get sick while on Antabuse."
☐ **2.** "I can take Antabuse at bedtime if it makes me sleepy."
☐ **3.** "A metallic or garlic taste in my mouth is normal when starting on Antabuse."
☐ **4.** "I'll read the labels on cough syrup and mouthwash for possible alcohol content."

50. While receiving disulfiram (Antabuse) therapy, the client becomes nauseated and vomits severely. Which of the following questions should the nurse ask **first**?
☐ **1.** "How long have you been taking Antabuse?"
☐ **2.** "Do you feel like you have the flu?"
"How much alcohol did you drink today?"
☐ **4.** "Have you eaten any foods cooked in wine?"

51. The expected outcome for using thiamine for a client being treated for an alcohol addiction is to:
Prevent the development of Wernicke's encephalopathy.
☐ **2.** Decrease client's withdrawal symptoms.
☐ **3.** Aid client in regaining strength sooner.
☐ **4.** Promote elimination of alcohol from the body faster.

52. Which of the following client statements indicates an understanding of the signs of alcohol relapse?
☐ **1.** "I know I can stay dry if my wife keeps alcohol out of the house."
"Stopping Alcoholics Anonymous (AA) and not expressing feelings can lead to relapse."
☐ **3.** "I'll have my sponsor at AA keep the list of symptoms for me."
☐ **4.** "If someone tells me I'm about to relapse, I'll be sure to do something about it."

53. The client sees no connection between her liver disorder and her alcohol intake. She believes that she drinks very little and that her family is making something out of nothing. The nurse interprets these behaviors as indicative of the client's use of which of the following defense mechanisms?

Denial.

☐ **2.** Displacement.

☐ **3.** Rationalization.

☐ **4.** Reaction formation.

54. Which of the following foods should the nurse eliminate from the diet of a client in alcohol withdrawal?

☐ **1.** Milk.

Regular coffee.

☐ **3.** Orange juice.

☐ **4.** Eggs.

55. A client with alcohol dependency has peripheral neuropathy. The nurse should develop a teaching plan that emphasizes:

☐ **1.** Washing and drying the feet daily.

☐ **2.** Massaging the feet with lotion.

☐ **3.** Trimming the toenails carefully.

Avoiding use of an electric blanket.

56. A client is experiencing alcohol withdrawal. He wakes up and screams, “There's something crawling under my skin. Help me.” In which order, from first to last, should the following nursing actions be done?

1. Remind the client that he is having withdrawal symptoms and that these will be treated.
2. Administer a dose of lorazepam (Ativan) depending on the severity of the withdrawal symptoms.
3. Assess the client for other withdrawal symptoms.
4. Take the client's vital signs.
5. Chart the details of the episode on the electronic health record.

57. Which of the following measures should the nurse include in the plan of care for a client with alcohol withdrawal delirium?

☐ **1.** Using restraints continuously.

☐ **2.** Touching the client before saying anything.

Remaining with the client when she is confused or disoriented.

☐ **4.** Informing the client about alcohol treatment programs.

58. Which of the following is an accurate response when a client asks the nurse about requirements to become a member of Alcoholics Anonymous (AA)?

☐ **1.** "You must be sober for at least a month before joining."

"AA is open to anyone who wants sobriety."

☐ **3.** "The members will interview you and decide if you can join the group."

☐ **4.** "AA requires daily attendance at meetings."

59. A client is to be discharged from an alcohol rehabilitation program. Which of the following should the nurse emphasize in the discharge plan as a priority?

☐ **1.** Supportive friends.

☐ **2.** A list of goals.

☐ **3.** Family forgiveness.

Follow-up care.

60. The client is to be discharged from the hospital after a safe, medically supervised withdrawal from alcohol. Which of the following outcomes indicate client readiness for an outpatient alcohol treatment program? Select all that apply.

☐ **1.** The client states the need to cut down on his alcohol intake.

The client verbalizes the damaging effects of alcohol on his body.

The client plans to attend Alcoholics Anonymous meetings.

The client takes naltrexone (ReVia) daily.

☐ **5.** The client says he is indestructible.

61. A client diagnosed with major depression and substance dependence is being admitted to the Dual Diagnosis Unit. In explaining the focus of this

program, the nurse should tell the client?

☐ **1.** The addiction will be treated first, then the depression.

☐ **2.** The depression with be treated first, then the addiction.

There will be simultaneous treatment of the addiction and depression.

☐ **4.** As the addiction is treated, the depression will clear up on its own.

62. While caring for a client who has a dual diagnosis of bipolar disorder and alcohol dependency, which of the following areas is the priority for daily assessment?

☐ **1.** Sleep pattern.

Mental status.

☐ **3.** Eating habits.

☐ **4.** Self-care ability.

63. A client diagnosed with schizophrenia and alcohol abuse decides to drink alcohol with his buddies. The nurse recognizes which of the following as the underlying dynamic of the client's alcohol use?

The decision to use alcohol is a wish to feel accepted by others.

☐ **2.** The decision to drink increases the client's guilt and shame.

☐ **3.** The client abused alcohol before developing a mental illness.

☐ **4.** The client is compelled to drink because of cognitive difficulties.

The Client with Disorders Related to Other Addictive Substances

64. A client is being admitted to the hospital following an inadvertent overdose with oxycodone. He reveals that he has chronic back pain that resulted from an injury on a construction site. He states, “I know I took too much oxycodone at once, but I can't live with this pain without them. You can't take them away from me.” Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “Once you are tapered off the oxycodone, you will find that nonaddictive pain medicines will be enough to control your pain.”

☐ **2.** “You are going to be switched from the oxycodone to methadone for long-term pain management.

☐ **3.** The oxycodone will be stopped tomorrow, but you will have lorazepam to help you with the withdrawal symptoms.

Your pain will be controlled by tapering doses of oxycodone, with other pain management strategies and medicines.

65. A school nurse is planning a program for parents on “Drugs Commonly Abused by Teenagers.” Which of the following information should be included about inhalants? Select all that apply.

Monitor for paper bags and rags that may have been used for breathing inhalants.

☐ **2.** Brain damage is unlikely with the use of inhalants.

☐ **3.** Use of inhalants by teens is on the decline.

Deaths from inhalants occur from asphyxiation, suffocation, and aspiration of vomit.

Inhalants usually cause depression of the central nervous system.

The basic groups of inhalants are hydrocarbon solvents such as glue, aerosol propellants from spray cans, and anesthetics/gases.

66. The friend of a client brought to the emergency department states, “I guess she had some bad junk (heroin) today.” The client is drowsy and verbally nonresponsive. Which of the following assessment findings is of immediate concern to the nurse?

Respiratory rate of 9 breaths/min.

☐ **2.** Urinary retention.

☐ **3.** Hypotension.
☐ **4.** Reduced pupil size.

67. A client is brought to the emergency department by a friend who states, “He was using a lot of heroin until he ran out of money about 2 days ago.” The nurse judges the client to be in opioid withdrawal if he exhibits which of the following? Select all that apply.
Rhinorrhea.
Diaphoresis.
Piloerection.
☐ **4.** Synesthesia.
☐ **5.** Formication.

68. An unconscious client in the emergency department is given IV naloxone (Narcan) due to an overdose of heroin. Which of the following would indicate a therapeutic response to the Narcan? Select all that apply.
☐ **1.** Decreased pulse rate.
☐ **2.** Warm skin.
☐ **3.** Dilated pupils.
Increased respirations.
Consciousness.

69. Which of the following should the nurse expect to assess for a client who is exhibiting late signs of heroin withdrawal?
Vomiting and diarrhea.
☐ **2.** Yawning and diaphoresis.
☐ **3.** Lacrimation and rhinorrhea.
☐ **4.** Restlessness and irritability.

70. After administering naloxone (Narcan), an opioid antagonist, the nurse should monitor the client carefully for which of the following?
☐ **1.** Cerebral edema.
☐ **2.** Kidney failure.
☐ **3.** Seizure activity.
Respiratory depression.

71. When teaching a client who is to receive methadone therapy for opioid addiction, the nurse should instruct the client that methadone is useful primarily for which of the following reasons?
☐ **1.** It is not an addictive substance.
☐ **2.** A maintenance dose is taken twice a day.
☐ **3.** The client will no longer be addicted to opioids.
The client may work and live normally.

72. A client states to the nurse, “I'm not going to any more Narcotics Anonymous meetings. I felt out of place there.” Which of the following responses by the nurse is best?

“Try attending a meeting at a different location; you may feel more comfortable there.”

☐ **2.** “Maybe it just wasn't a good day for you. Everybody has bad days now and then.”

☐ **3.** “Perhaps you weren't paying close enough attention to what they were saying.”

☐ **4.** “Sometimes the meetings can seem like a waste of time, but you need to attend to stay clean.”

73. Which of the following should the nurse use as the best measure to determine a client's progress in rehabilitation?

☐ **1.** The kinds of friends he makes.

The number of drug-free days he has.

☐ **3.** The way he gets along with his parents.

☐ **4.** The amount of responsibility his job entails.

74. Which of the following should lead the nurse to suspect that a client is addicted to heroin?

☐ **1.** Hilarity.

☐ **2.** Aggression.

☐ **3.** Labile mood.

Hypoactivity.

75. A client brought by ambulance to the emergency department after taking an overdose of barbiturates is comatose. The nurse should assess the client for:

☐ **1.** Kidney failure.

☐ **2.** Cerebrovascular accident.

☐ **3.** Status epilepticus.

Respiratory failure.

76. The client's friend reports that the client has been taking about eight “reds” (800 mg of secobarbital [Seconal]) daily, besides drinking more alcohol than usual. The client's friend asks anxiously, “Do you think she will live?” Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “We can only wait and see. It's too soon to tell.”

☐ **2.** “Do you know her well? She's so young.”

☐ **3.** “She is very ill and may not live. Some don't pull through.”

“Her condition is serious. You sound very worried about her.”

77. Before his hospitalization, a client needed increasingly larger doses of

barbiturates to achieve the same euphoric effect he initially realized from their use. From this information, the nurse develops a plan of care that takes into account that the client is likely suffering from which of the following?

Tolerance.

☐ **2.** Addiction.

☐ **3.** Abuse.

☐ **4.** Dependence.

78. Which of the following statements by the nurse is most appropriate when addressing a client with a barbiturate overdose who awakens in a confused state and exhibits stable vital signs?

☐ **1.** "I'm here to help you beat your drug habit. But it's you who will need to work hard."

☐ **2.** "It's time to get straight and stay clean and put an end to your torture."

☐ **3.** "I'm glad you pulled through; it was touch and go with you for a while."

"You're in the hospital because of a drug problem; I'm one of the nurses who will help you."

79. A client states that her "life has gone down the tubes" since her divorce 6 months ago. Then, after she lost her job and apartment, she took an overdose of barbiturates so she "could go to sleep and never wake up." Which of the following statements by the nurse should be made **first**?

☐ **1.** "It seems as if your self-esteem has been affected by all your losses."

"I know you took an overdose of barbiturates. Are you thinking of suicide now?"

☐ **3.** "Helplessness is common after losing a job. Are you having trouble making decisions?"

☐ **4.** "You sound hopeless about the future since your divorce."

80. A client who has experienced the loss of her husband through divorce, the loss of her job and apartment, and the development of drug dependency is suffering situational low self-esteem. Which of the following outcomes is **most** appropriate initially?

The client will discuss her feelings related to her losses.

☐ **2.** The client will identify two positive qualities.

☐ **3.** The client will explore her strengths.

☐ **4.** The client will prioritize problems.

81. The nurse notices that a client recovering from a barbiturate overdose spends most of his time with other young adults who have substance-related problems. This group of clients is a dominant force on the unit, keeping the nondrug users entertained with stories of their "highs." Which of the following

methods is **best** to use when dealing with this problem?

☐ **1.** Providing additional recreation.

☐ **2.** Breaking up drug-oriented discussions.

☐ **3.** Speaking with the clients individually about their behavior.

Discussing the behavior at the daily community meeting.

82. A client recovering from a drug overdose is interacting with the nurse and recounting her exploits at numerous parties she's attended. Which of the following actions is **most** therapeutic?

☐ **1.** Allowing the client to continue with her stories.

☐ **2.** Telling the client you've heard the stories before.

☐ **3.** Questioning the client further about her exploits.

Directing the conversation to realistic concerns.

83. The nurse is speaking to a sixth grade class about drugs. A student states, "I know someone who smokes marijuana and he says it's safe." The nurse should tell the student:

☐ **1.** "Marijuana isn't safe, and it is illegal."

☐ **2.** "Do you really believe him?"

"That drug causes more damage to your body than regular cigarettes."

☐ **4.** "Marijuana usage can lead to using other chemicals."

84. When developing a teaching plan for a group of middle school children about the drug 3,4-methylenedioxymethamphetamine (Ecstasy), what information should the nurse expect to include? Select all that apply.

Using Ecstasy is similar to using speed.

Ecstasy is used at all-night parties.

☐ **3.** Teeth grinding is seen with cocaine, not Ecstasy use.

It can cause death.

It reduces self-consciousness.

85. A young client is being admitted to the psychiatric unit after her obstetrician's staff suspected she was experiencing a postpartum psychosis. Her husband said she was doing fine for 2 weeks after the birth of the baby, except for pain from the C-section and trouble sleeping. These symptoms subsided over the next 4 weeks. Then 3 days ago, the client started having anxiety, irritability, vomiting, diarrhea, and delirium, resulting in her inability to care for the baby. Then the husband says, "I saw that my bottles of alprazolam and oxycodone were empty even though I haven't been taking them." In what order of priority from first to last should the nurse do the following?

1. Call the physician for prescriptions for appropriate treatment for opiate and benzodiazepine withdrawal.

2. Immediately place the client on withdrawal precautions.

3. Confirm with the client that she has in fact been using her husband's medications.

4. Assess the client for prior and current use of any other substances.

86. A 68-year-old client is admitted to the addiction unit after treatment in the Emergency Department for an overdose of Percocet (oxycontin). Her son calls the unit and expresses intense anger that his mother is being treated as a "common street addict." He says she has severe back pain and was given that prescription by her doctor. "She just accidentally took a few too many pills last night." Which reply by the nurse is **most** therapeutic?

☐ **1.** "I understand that your mother may not have intentionally taken too many pills. This medication can cause one to forget how many have been taken."

☐ **2.** "It may be appropriate for your mother to be referred to a pain management program."

☐ **3.** "Unfortunately, it is fairly common for clients with pain to increase their use of pain pills over time."

"I can hear how upset you are. You sound very concerned about your mother."

87. A client is being admitted to the addictions unit for a confirmed and long-term addiction to Xanax (alprazolam). She continues to strongly deny her addiction, stating she was prescribed the Xanax to control her "panic attacks." Which of the following procedures would be the most important during the admission process? Select all that apply.

Assess the client for suicide, escape, and aggression risks.

With the client present, search the client's clothes and belongings for contraband and restricted items.

Initiate withdrawal precautions.

☐ **4.** Explain the unit routine and types of groups.

Obtain a urine specimen for a urine drug screen.

88. A client is returning to the primary care physician's office for follow-up on his diagnosis of coronary artery disease. After all the appropriate exams and assessments are completed, the nurse asks the client about how well he is sleeping. The client states, “Oh, that's not a problem anymore. I take a couple of my wife's Valiums (diazepam) and sleep like a baby.” Which of the following information should the nurse obtain? Select all that apply.

☐ **1.** The reason the client's wife is taking Valium.

The dose of the Valium he is taking and how long he has been taking it.

Exactly how many Valiums he takes at night and during the day,

☐ **4.** Whether he intends to stop the Valium use.

What was interfering with his sleep prior to starting the Valium.

89. A client who chronically snorts cocaine is brought to the emergency department due to a cocaine overdose. The client is experiencing delusions, hallucinations, mild respiratory distress, and mild tachycardia initially. The nurse should do which of the following? Select all that apply.

☐ **1.** Induce vomiting.

Place seizure pads on the bed.

Administer PRN haloperidol (Haldol) as prescribed.

Monitor for respiratory acidosis.

Encourage deep breathing.

Monitor for metabolic acidosis.

90. A client walks into the clinic and tells the nurse she has run out of money for crack, has crashed, and wants something to help her feel better. Which of the following is most important for the nurse to assess?

☐ **1.** Suspiciousness.

☐ **2.** Loss of appetite.

☐ **3.** Drug craving.

Suicidal ideation.

91. A client in the emergency department is diagnosed as having amphetamine psychosis. The nurse should take all of the following actions in which order of priority from first to last?

1. Transfer the client to the psychiatric unit.

2. Monitor cardiac and respiratory status.

3. Place seizure pads on the bed.

4. Administer IM haloperidol (Haldol) as prescribed.

92. A client has been taking increased amounts of alprazolam (Xanax) for about 6 months for anxiety. She asks the nurse how she can "get off the Xanax." The most accurate answer by the nurse is which of the following?

☐ **1.** "There will be an immediate discontinuation of the Xanax and haloperidol (Haldol) will be available if needed."

"Instead of Xanax, you will take lorazepam (Ativan) in decreasing doses and frequency over a period of 3 to 4 days."

☐ **3.** "The Xanax will be tapered down over a period of 48 hours."

☐ **4.** "Xanax will be available on an as-needed basis for 4 to 5 days."

93. The client is fidgeting and has trouble sitting still. He has difficulty concentrating and is tangential. Which of the following interventions should help decrease this client's level of anxiety? Select all that apply.

Refocusing attention.

Allowing ventilation.

☐ **3.** Suggesting a time-out.

☐ **4.** Giving intramuscular medication.

Assisting with problem solving.

94. When caring for a client who has overdosed on phencyclidine (PCP), the nurse should be especially cautious about which of the following client behaviors?

☐ **1.** Visual hallucinations.

Violent behavior.
☐ **3.** Bizarre behavior.
☐ **4.** Loud screaming.

95. Which of the following liquids should the nurse administer to a client who is intoxicated on phencyclidine (PCP) to hasten excretion of the chemical?
☐ **1.** Water.
☐ **2.** Milk.
Cranberry juice.
☐ **4.** Grape juice.

96. When assessing a client with possible alcohol poisoning, the nurse should investigate the client's use of which of the following substances while drinking alcohol?
Marijuana.
☐ **2.** Lysergic acid diethylamide.
☐ **3.** Peyote.
☐ **4.** Psilocybin.

97. A client with a cocaine dependency is irritable, anxious, highly sensitive to stimuli, and overreactive to clients and staff on the unit. Which of the following actions is **most** therapeutic for this client?
☐ **1.** Secluding and restraining the client as needed.
☐ **2.** Telling the client to stay in his room until he can control himself.
Providing the client with frequent “time-outs.”
☐ **4.** Confronting the client about his behaviors.

98. A client with symptoms of amphetamine psychosis that are improving is anxious and still experiencing some delusions. When developing the client's plan of care, which of the following measures should the nurse include?
☐ **1.** Assign the client to a group meeting about the physiologic effects of drugs.
☐ **2.** Advise the client to watch television.
☐ **3.** Wait for the client to approach the nurse.
Invite the client to play a game of ping-pong with the nurse.

99. In consultation with his outpatient psychiatrist, a client is admitted for detoxification from methadone. He states, “I got addicted to morphine for my chronic knee pain. Methadone worked for a long time. Since I had my knee replacement surgery 3 months ago and physical therapy, I don't think I need methadone any more.” It is important to discuss which of the following pieces of information with this client? Select all that apply.
“Detoxification will likely occur with slowly decreasing doses of methadone.”

☐ **2.** “Oxycodone will be available if needed for break-through-pain.”

“You will be monitored closely for withdrawal symptoms and treated as needed.”

“Physical therapy and nonchemical pain management techniques can be prescribed if needed.”

“If you have knee stiffness or pain, it is likely to be managed by nonnarcotic pain medicines.”

100. A client approaches the medication nurse and states, “I can't believe you are NOT helping me with my cravings for my fentanyl patches! When I got off alcohol 2 years ago, they gave me naltrexone for my cravings, and it really helped. I can't stand the cravings and back pain anymore, and I'm getting angry.” Which of the following responses by the nurse would be helpful for this client? Select all that apply.

“Naltrexone does help decrease the cravings for alcohol.”

“Naltrexone can interfere with opiate cravings in some clients.”

“Cravings are hard to deal with, especially when you are in pain too.”

“I hear your frustration about how your detoxification is going.”

☐ **5.** “I am positive naltrexone can help with your cravings for fentanyl.”

“I can ask your physician if he thinks naltrexone might help you.”

The Client with Anxiety Disorders and Anxiety-Related Disorders

101. A 17-year-old female client who has been treated for an anxiety disorder since middle school with behavioral treatment and as-needed (PRN) anxiety medication is preparing to go to college. The parents are concerned that she will experience an exacerbation of symptoms if she attends college out of town and want the daughter to attend the local community college and live at home. The girl believes she can handle the challenge of leaving home for college. How should the nurse in the outpatient clinic respond to the family's concerns?

☐ **1.** "Your parents have a point; transitions have been hard for you in the past."

"There are many pros and cons here that we all need to discuss together."

☐ **3.** "Every high school graduate deserves the chance to take on new challenges."

☐ **4.** "It may be premature for you to think of college at this point in time."

102. A 16-year-old boy who is academically gifted is about to graduate from high school early since he has completed all courses needed to earn a diploma. Within the last 3 months he has begun to experience panic attacks that have forced him to leave classes early and occasionally miss a day of school. He is concerned that these attacks may hinder his ability to pursue a college degree. What would be the *best* response by the school nurse who has been helping him deal with his panic attacks?

☐ **1.** "It is natural to be worried about going into a new environment. I am sure with your abilities you will do well once you get settled."

☐ **2.** "You are putting too much pressure on yourself. You just need to relax more and things will be alright."

☐ **3.** "It might be best for you to postpone going to college. You need to get these panic attacks controlled first."

"It sounds like you have real concern about transitioning to college. I can refer you to a health care provider for assessment and treatment."

103. A client has been diagnosed with posttraumatic stress disorder (PTSD) because he experienced childhood sexual abuse (CSA) by his babysitter and her boyfriend from ages 4 to 10. He is admitted for the second time after physically

assaulting a woman he said was a prostitute. “She is no better than my babysitter and deserves to be dead. I'd like to kill the sitter too.” With the knowledge of PTSD and CSA, which of the following nursing interventions should be implemented at admission? Select all that apply.

Institute precautions for suicide, assault, and escape.

Ask him to sign a no harm contract.

Provide safe outlets for his anger and rage.

☐ **4.** Encourage him to express his attitude toward prostitutes during unit group sessions.

In one-to-one staff talks, encourage him to safely verbalize his anger toward his babysitter and her boyfriend.

104. A client is taking diazepam (Valium) for generalized anxiety disorder. Which instruction should the nurse give to this client? Select all that apply.

To consult with his health care provider before he stops taking the drug.

☐ **2.** To avoid eating cheese and other tyramine-rich foods.

☐ **3.** To take the medication on an empty stomach.

Not to use alcohol while taking the drug.

To stop taking the drug if he experiences swelling of the lips and face and difficulty breathing.

105. An adult client diagnosed with anxiety disorder becomes anxious when she touches fruits and vegetables. What should the nurse do?

☐ **1.** Instruct the woman to avoid touching these foods.

☐ **2.** Ask the woman why she becomes anxious in these situations.

☐ **3.** Assist the woman to make a plan for her family to do the food shopping and preparation.

Teach the woman to use cognitive behavioral approaches to manage her anxiety.

106. A client who is pacing and wringing his hands states, “I just need to walk” when questioned by the nurse about what he is feeling. Which of the following responses by the nurse is most therapeutic?

☐ **1.** “You need to sit down and relax.”

“Are you feeling anxious?”

☐ **3.** “Is something bothering you?”

☐ **4.** “You must be experiencing a problem now.”

107. A client brought to the emergency department is perspiring profusely, breathing rapidly, and having dizziness and palpitations. Problems of a cardiovascular nature are ruled out, and the client's diagnosis is tentatively listed as a panic attack. After the symptoms pass, the client states, “I thought I was going to die.” Which of the following responses by the nurse is **best**?

“It was very frightening for you.”
☐ **2.** “We would not have let you die.”
☐ **3.** “I would have felt the same way.”
☐ **4.** “But you're okay now.”

108. A client commonly jumps when spoken to and reports feeling uneasy. The client says, “It's as though something bad is going to happen.” In which order from first to last should the following nursing actions be done?

1. Teach problem-solving strategies.
2. Ask the client to deep breathe for 2 minutes.
3. Discuss the client's feelings in more depth.
4. Reduce environmental stimuli.

109. Which of the following points should the nurse include when teaching a client about panic disorder?
☐ **1.** Staying in the house will eliminate panic attacks.
☐ **2.** Medication should be taken when symptoms start.
Symptoms of a panic attack are time limited and will abate.
☐ **4.** Maintaining self-control will decrease symptoms of panic.

110. A client with panic disorder is taking alprazolam (Xanax) 1 mg PO three times daily. The nurse understands that this medication is effective in blocking the symptoms of panic because of its specific action on which of the following neurotransmitters?
Gamma-aminobutyrate.
☐ **2.** Serotonin.
☐ **3.** Dopamine.

☐ **4.** Norepinephrine.

111. A client is diagnosed with generalized anxiety disorder (GAD) and given a prescription for venlafaxine (Effexor). Which of the following information should the nurse include in a teaching plan for this client? Select all that apply.

Various strategies for reducing anxiety.

The benefits and mechanisms of actions of Effexor in treating GAD.

☐ **3.** How Effexor will eliminate his anxiety at home and work.

The management of the common side effects of Effexor.

Substituting adaptive coping strategies for maladaptive ones.

☐ **6.** The positive effects of Effexor being evident in 4 to 5 days.

112. While a client is taking alprazolam (Xanax), which of the following should the nurse instruct the client to avoid?

☐ **1.** Chocolate.

☐ **2.** Cheese.

Alcohol.

☐ **4.** Shellfish.

113. Which of the following statements by a client who has been taking buspirone (BuSpar) as prescribed for 2 days indicates the need for further teaching?

"This medication will help my tight, aching muscles."

☐ **2.** "I may not feel better for 7 to 10 days."

☐ **3.** "The drug does not cause physical dependence."

☐ **4.** "I can take the medication with food."

114. A week ago, a tornado destroyed the client's home and seriously injured her husband. The client has been walking around the hospital in a daze without any outward display of emotions. She tells the nurse that she feels like she's going crazy. Which of the following actions should the nurse use **first**?

☐ **1.** Explain the effects of stress on the mind and body.

Reassure the client that her feelings are typical reactions to serious trauma.

☐ **3.** Reassure the client that her symptoms are temporary.

☐ **4.** Acknowledge the unfairness of the client's situation.

115. After being discharged from the hospital with acute stress disorder, a client is referred to the outpatient clinic for follow-up. Which of the following is **most** important for the client to use for continued alleviation of anxiety?

☐ **1.** Recognizing when she is feeling anxious.

☐ **2.** Understanding reasons for her anxiety.

Using adaptive and palliative methods to reduce anxiety.

☐ **4.** Describing the situations preceding her feelings of anxiety.

116. A client with acute stress disorder states to the nurse, “I keep having horrible nightmares about the car accident that killed my daughter. I shouldn't have taken her with me to the store.” Which of the following responses by the nurse is **most** therapeutic?

☐ **1.** “Don't keep torturing yourself with such horrible thoughts.”
☐ **2.** “Stop blaming yourself. It's only hurting you.”
☐ **3.** “Let's talk about something that is a bit more pleasant.”
“The accident just happened and could not have been predicted.”

117. The client, a veteran of the Vietnam war who has posttraumatic stress disorder, tells the nurse about the horror and mass destruction of war. He states, “I killed all of those people for nothing.” Which of the following responses by the nurse is appropriate?

“You did what you had to do at that time.”
☐ **2.** “Maybe you didn't kill as many people as you think.”
☐ **3.** “How many people did you kill?”
☐ **4.** “War is a terrible thing.”

118. A client with acute stress disorder has avoided feelings of anger toward her rapist and cannot verbally express them. The nurse suggests which of the following activities to assist the client with expressing her feelings?

☐ **1.** Working on a puzzle.
Writing in a journal.
☐ **3.** Meditating.
☐ **4.** Listening to music.

119. When developing the plan of care for a client with acute stress disorder who lost her sister in a boating accident, which of the following should the nurse initiate?

☐ **1.** Helping the client to evaluate her sister's behavior.
☐ **2.** Telling the client to avoid details of the accident.
Facilitating progressive review of the accident and its consequences.
☐ **4.** Postponing discussion of the accident until the client brings it up.

120. A soldier on his second tour of dutywas notified of the date that he will be redeployed. As this date approaches, he is showing signs of excess anxiety and irritability and inability to sleep at night because of nightmares of IED (improvised explosive devices) tragedies, all leading to poor work performance. His commanding officer refers him to the base hospital for an evaluation. The admitting nurse should take the following actions in order of priority from first to last?

1. Remind him that any feelings and problems he is having are typical in his current situation.

2. Ask him to talk about his upsetting experiences.

3. Remove any weapons and dangerous items he has in his possession.

4. Acknowledge any injustices/unfairness related to his experiences and offer empathy and support.

121. A newly admitted 20-year-old client, diagnosed with posttraumatic stress disorder (PTSD), reluctantly reveals that she escaped from a satanic cult 2 years ago. The mother has been in the cult since the client was 3 years old and refused to leave with the client. The client says, "Nobody will ever believe the horrible things the men did to me, and my mother never stopped them." Which of the following responses is appropriate for the nurse to make?

☐ **1.** "I'll believe anything you tell me. You can trust me."
☐ **2.** "I can't understand why your mother didn't protect you. It's not right."
☐ **3.** "Tell me about the cult. I didn't know there were any near here."
"It must be difficult to talk about what happened. I'm willing to listen."

122. A 15-year-old client diagnosed with posttraumatic stress disorder (PTSD) is admitted to the unit after slicing both arms with a razor blade. He says, "Maybe my mother will listen to me now. She tells me I'm just crazy when I say I'm screwed up because my stepdad had sex with me for years." The nurse should do the following in which order of priority first to last?

1. Ask the client about the stepdad possibly abusing younger children in the family.

2. Ask the client to be specific about what he means by “screwed up.”

3. Ask the client to sign a No Harm Contract related to suicide and self-mutilation.

4. Ask the client to talk about appropriate ways to express anger toward his mother.

123. A client diagnosed with posttraumatic stress disorder is readmitted for suicidal thoughts and continued trouble sleeping. She states that when she closes her eyes, she has vivid memories about being awakened at night. “My dad would be on top of me trying to have sex with me. I couldn't breathe.” Which of the following suggestions would be appropriate for the nurse to make for the insomnia? Select all that apply.

Trying relaxation techniques to help decrease her anxiety before bedtime.

Taking the quetiapine (Seroquel) 25 mg as needed as prescribed by the primary health care provider.

☐ **3.** Staying in the dayroom and trying to sleep in the recliner chair near staff.

Listening to calming music as she tries to fall asleep.

☐ **5.** Processing the content of her flashbacks no less than an hour before bedtime.

Leaving her door slightly open to decrease noise during the nightly checks.

124. A client with posttraumatic stress disorder needs to find new housing and wants to wait for a month before setting another appointment to see the nurse. The nurse interprets this action as which of the following?

☐ **1.** A method of avoidance.

☐ **2.** A detriment to progress.

☐ **3.** The end of treatment.

A necessary break in treatment.

125. The nurse should warn a client who is taking a benzodiazepine about

using which of the following medications in combination with his current medication?
Antacids.
☐ **2.** Acetaminophen (Tylenol).
☐ **3.** Vitamins.
☐ **4.** Aspirin.

126. Which of the following client statements indicates the need for additional teaching about benzodiazepines?
☐ **1.** “I can't drink alcohol while taking diazepam (Valium).”
“I can stop taking the drug anytime I want.”
☐ **3.** “Valium can make me drowsy, so I shouldn't drive for a while.”
☐ **4.** “Valium will help my tight muscles feel better.”

127. A client is diagnosed with agoraphobia without panic disorder. Which type of therapy is **most** effective for this illness?
☐ **1.** Insight therapy.
☐ **2.** Group therapy.
Behavior therapy.
☐ **4.** Psychoanalysis.

128. The client diagnosed with a fear of eating in public places or in front of other people has finished eating lunch in the dining area in the nurse's presence. Which of the following statements by the nurse should reinforce the client's positive action?
☐ **1.** “It wasn't so hard, now was it?”
☐ **2.** “At supper, I hope to see you eat with a group of people.”
☐ **3.** “You must have been hungry today.”
“It is progress for you to eat in the dining room with me.”

129. The client diagnosed with agoraphobia refuses to walk down the hall to the group room. Which of the following responses by the nurse is appropriate?
☐ **1.** “I know you can do it.”
☐ **2.** “Try holding onto the wall as you walk.”
☐ **3.** “You can miss group this one time.”
“I'll walk with you.”

130. A client diagnosed with obsessive-compulsive disorder has been taking sertraline (Zoloft) but would like to have more energy every day. At his monthly checkup, he reports that his massage therapist recommended he take St. John's wort to help his depression. The nurse should tell the client:
☐ **1.** “St. John's wort is a harmless herb that might be helpful in this instance.”
“Combining St. John's wort with the Zoloft can cause a serious reaction called

serotonin syndrome."

☐ **3.** "If you take St. John's, we'll have to decrease the dose of your Zoloft."

☐ **4.** "St. John's wort isn't very effective for depression, but we can increase your Zoloft dose."

131. A client diagnosed with obsessive-compulsive disorder arrives late for an appointment with the nurse at the outpatient clinic. During the interview, he fidgets restlessly, has trouble remembering what topic is being discussed, and says he thinks he is going crazy. Which of the following statements by the nurse best deals with the client's feelings of "going crazy?"

"What do you mean when you say you think you're going crazy?"

☐ **2.** "Most people feel that way occasionally."

☐ **3.** "I don't know you well enough to judge your mental state."

☐ **4.** "You sound perfectly sane to me."

132. A client with obsessive-compulsive disorder reveals that he was late for his appointment "because of my dumb habit. I have to take off my socks and put them back on 41 times! I can't stop until I do it just right." The nurse interprets the client's behavior as most likely representing an effort to obtain which of the following?

Relief from anxiety.

☐ **2.** Control of his thoughts.

☐ **3.** Attention from others.

☐ **4.** Safe expression of hostility.

133. A client with obsessive-compulsive disorder, who was admitted early yesterday morning, must make his bed 22 times before he can have breakfast. Because of his behavior, the client missed having breakfast yesterday with the other clients. Which of the following actions should the nurse institute to help the client be on time for breakfast?

☐ **1.** Tell the client to make his bed one time only.

Wake the client an hour earlier to perform his ritual.

☐ **3.** Insist that the client stop his activity when it's time for breakfast.

☐ **4.** Advise the client to have breakfast first before making his bed.

134. The nurse notices that a client diagnosed with major depression and social phobia must get up and move to another area when someone sits next to her. Which of the following actions by the nurse is appropriate?

☐ **1.** Ignore the client's behavior.

☐ **2.** Question the client about her avoidance of others.

Convey awareness of the client's anxiety about being around others.

☐ **4.** Tell the other clients to follow the client when she moves away.

135. The nurse is developing a long-term care plan for an outpatient client diagnosed with dissociative identity disorder. Which of the following should be included in this plan? Select all that apply.

Learning how to manage feelings, especially anger and rage.

☐ **2.** Joining several outpatient support groups that are process-oriented.

Identifying resources to call when there is a risk of suicide or self-mutilation.

Selecting a method for alter personalities to communicate with each other, such as journaling.

☐ **5.** Trying different medicines to find one that eliminates the dissociative process.

Helping each alter accept the goal of sharing and integrating all their memories.

136. A comanager of a convenience store was taking the daily receipts to the bank when she was robbed at gunpoint. She did not report the robbery and could not be found for 2 days. In a city 100 miles (161 km) away, a hotel manager called the police because the woman gave a false name and address. After learning that the robbery was confirmed by the bank cameras, she was admitted to the hospital with a diagnosis of dissociative fugue. The nurse should include which of the following in the client's care plan? Select all that apply.

Develop trust and rapport to provide safety and support.

Rule out possible physical and neurological causes for the fugue.

Help the client discuss what she can remember about the trip to the bank.

☐ **4.** Seclude the client from the other clients because of her lack of memory.

☐ **5.** Question her repeatedly about the robbery and how she responded.

Encourage the client to talk about her feelings about what has been happening.

137. A client with a long history of experiencing dissociative identity disorder is admitted to the unit after the cuts on her legs were sutured in the Emergency Department. During the admission interview, the client tearfully states that she does not know what happened to her legs. Then a stronger, alter personality states that the client is useless, weak, and needs to be eliminated completely. The nurse should do which of the following **first**?

☐ **1.** Explore the alter personalities' attitudes toward the client more thoroughly.

☐ **2.** Place the client in restraints when the alter personality emerges.

Contract with the alter personality to tell the nurse when he has the urge to harm the client and the body they both share.

☐ **4.** Keep the client in a stress-free environment so that the stronger alter personality does not get a chance to emerge.

The Client with a Somatoform Disorder

138. At 10 AM, a client with an Axis I diagnosis of pain disorder demands that the nurse call the primary health care provider for more pain medication because she's still in pain after the 9 AM analgesic. Which of the following should the nurse do next?

☐ **1.** Call the primary health care provider as the client requests.
☐ **2.** Suggest the client lie down while she is waiting for her next dose.
☐ **3.** Tell the client that the primary health care provider will be in later to talk to her about it.
Inform the client that the nurse cannot give her additional medication at this time.

139. The unlicensed assistive personnel (UAP) tells the nurse that the client with a somatoform disorder is sick and is not coming to the dining room for lunch. The nurse should direct the UAP to do which of the following?

☐ **1.** Take the client a lunch tray and let him eat in his room.
☐ **2.** Tell the client he'll need to wait until supper to eat if he misses lunch.
Invite the client to lunch and accompany him to the dining room.
☐ **4.** Inform the client that he has 10 minutes to get to the dining room for lunch.

140. The client diagnosed with conversion disorder has a paralyzed arm. A staff member states, “I would just tell the client her arm is paralyzed because she had an affair and neglected her baby's care to the point where the baby had to be hospitalized for dehydration.” Which of the following responses by the nurse is **best**?

☐ **1.** “Ignore the client's behaviors and treat her with respect.”
“Pushing insight will increase the client's anxiety and the need for physical symptoms.”
☐ **3.** “Pushing awareness will be helpful and further the client's recovery.”
☐ **4.** “We'll meet with the client and confront her with her behavior.”

141. The primary health care provider refers a client diagnosed with somatization disorder to the outpatient clinic because of problems with nausea. The client's past symptoms involved back pain, chest pain, and problems with urination. The client tells the nurse that the nausea began when his wife asked him for a divorce. Which of the following is **most** appropriate?

☐ **1.** Asking the client to describe his problem with nausea.

Directing the client to describe his feelings about his impending divorce.

☐ **3.** Allowing the client to talk about the primary health care providers he has seen and the medications he has taken.

☐ **4.** Informing the client about a different medication for his nausea.

142. A client diagnosed with pain disorder is talking with the nurse about fishing when he suddenly reverts to talking about the pain in his arm. Which of the following should the nurse do next?

☐ **1.** Allow the client to talk about his pain.

☐ **2.** Ask the client if he needs more pain medication.

☐ **3.** Get up and leave the client.

Redirect the interaction back to fishing.

143. Which of the following statements indicates to the nurse that the client is progressing toward recovery from a somatoform disorder?

"I understand my pain will feel worse when I'm worried about my divorce."

☐ **2.** "My stomach pain will go away once I get properly diagnosed."

☐ **3.** "My headache feels better when I time my medication dose."

☐ **4.** "I need to find a doctor who understands what my pain is like."

Managing Care Quality and Safety

144. A client is brought to the emergency department (ED) by a friend who states that the client recently ran out of his lorazepam (Ativan) and has been having a grand mal seizure for the last 10 minutes. The nurse observes that the client is still seizing. The nurse should do the following in which order of priority from first to last?

1. Monitor the client's safety and place seizure pads on the cart rails.

2. Record the time, duration, and nature of the seizures.

3. Page the ED primary health care provider and prepare to give diazepam (Valium) intravenously.

4. Ask the friend about the client's medical history and current medications.

145. A 33-year-old client named Becky, who is diagnosed with dissociative identity disorder, is admitted to the unit after a suicide attempt. During a group therapy session the next morning, the topic of anger toward parents came up. Becky suddenly throws herself on the floor and starts screaming, “Mommy, Mommy, help Annie girl, help Annie girl.” The nurse should take the following actions in which order of priority from first to last?

1. Ask the other clients to leave the room and meet with another nurse.

2. Ask Becky to talk about what happened to her during the group therapy session.

3. Get close to Annie and protect her from injury until she calms down.

4. Ask Annie about what happened to her during the group.

146. The client is in the emergency department with her boyfriend. She is just recovering from a "bad trip" from lysergic acid diethylamide (LSD). She is still frightened and a little suspicious. Which of the following nursing actions is most appropriate?

Having a sitter stay with the client to decrease her fear.

☐ **2.** Placing the client next to the nursing desk.

☐ **3.** Leaving the client alone until the "trip" is over.

☐ **4.** Having the boyfriend check on the client frequently.

147. A client on a stretcher in the emergency department begins to thrash around, slap the sheets, and yell, "Get these bugs off of me." She is disoriented and has a blood pressure of 189/75 and a pulse of 96. The friend who is with her says, "She was drinking *a lot* 3 days ago and asked me for money to get more vodka, but I didn't have any." The nurse should do the following in which order from first to last?

1. Obtain a prescription to place the client in restraints, if needed.

2. Implement constant observation.

3. Monitor vital signs every 15 minutes.

4. Administer haloperidol (Haldol) and lorazepam (Ativan) IM as prescribed.

5. Remind the client that she is in the hospital and the nurse is with her.

6. Chart the client's response to the interventions.

148. The nurse is teaching unlicensed staff about caring for the client with alcohol dependency. Which of the following statements by the staff indicates the need for additional teaching?

☐ **1.** "Alcohol dependency affects the entire family."

"The client is a weak individual and could stop if he desires."

☐ **3.** "Alcohol is a problem when it interferes with the client's daily life."

☐ **4.** "The client who can't stop drinking even though he wants to is alcohol dependent."

149. The nurse is serving on the hospital ethics committee that is considering the ethics of a proposal for the nursing staff to search the room of a client diagnosed with substance abuse while he is off the unit and without his knowledge. Which of the following should be considered concerning the relationship of ethical and legal standards of behavior?

Ethical standards are generally higher than those required by law.

☐ **2.** Ethical standards are equal to those required by law.

☐ **3.** Ethical standards bear no relationship to legal standards for behavior.

☐ **4.** Ethical standards are irrelevant when the health of a client is at risk.

150. Two nurses are working on a pediatric unit. Over the past week, Nurse 1 has noticed that Nurse 2 is complaining more about her chronic back pain. Nurse 2 also says she is tired and drowsy at work. She is having trouble

remembering which treatments she has done. Around the same time, a client of Nurse 2 reports that his pain medication is not helping at all. Nurse 1 asks Nurse 2 to have lunch with her to address her concerns about her. In which order of priority from first to last should Nurse 1 address the following issues with Nurse 2?

1. The type, dose, and frequency of use of the pain medication by Nurse 2.

2. The importance of the two of them going to their supervisor about Nurse 2's recent problems.

3. Nurse 1's genuine concern about Nurse 2, her pain, and behaviors.

4. Nurse 1's suspicion that Nurse 2 may be using a client's pain medication for herself.

151. A client with a history of cocaine abuse is receiving intravenous therapy and exits the hospital “to visit a friend.” The client returns to the nursing unit 1 hour later, agitated, aggressive, combative, and reporting “chest pain.” Place the nurse's actions in priority order.

1. Contact the security department.

2. Obtain an EKG.

3. Initiate a referral to obtain drug rehabilitation counseling.

4. Obtain a prescription for a urine sample.

Answers, Rationales, and Test-Taking Strategies

The answers and rationales for each question follow below, along with keys ( *) to the client need (CN) and cognitive level (CL) for each question. As you check your answers, use the* ***Content Mastery and Test-Taking Skill Self-Analysis*** *worksheet (tear-out worksheet in back of book) to identify the reason(s) for not answering the questions correctly. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21 and pages 31–32 in Part 1 of this book.*

The Client with a Personality Disorder

1.

3. Talk with the client about his self-esteem and his fears.

1. Teach the client anxiety management and social skills.

4. Help the client make a list of small group activities at the center he would find interesting.

2. Ask the client to join one of his chosen activities with the nurse and two other clients.

The client needs a stepwise plan for developing a social life. He needs to first work on his self-esteem and reduce his fears of rejection before talking about how to decrease his anxiety and learning new social skills. Helping him chose interesting activities is important before suggesting an activity for him. Then he will be ready to try a structured activity with the nurse present for support and role modeling.

 CN: Psychosocial integrity; CL: Synthesize

2. 3. The client is at risk for suicide, and the nurse should determine how

serious the client is, including if she has a plan and the means to implement the plan. While medication history may be important, the nurse should first attempt to determine suicide risk. Asking the client why she cut herself will likely cause the client to respond with insufficient information to determine suicide risk.

 CN: Reduction of risk potential; CL: Synthesize

3. 1. The nurse should plan to assist the client who has a personality disorder primarily with specific dysfunctional behaviors that are distressing to the client or others. The client with a personality disorder has lifelong, inflexible, and dysfunctional patterns of relating and behaving. The client commonly does not view his behavior as distressful to himself. The client becomes distressed because of others' reactions and behaviors toward him, which cause the client emotional pain and discomfort. Psychopharmacologic compliance is not a primary need because medication does not cure a personality disorder. Medication is prescribed if the client has a severe symptom that interferes with functioning, such as severe anxiety or depression, or if the client has an Axis I disorder. Examination of developmental conflicts usually is not helpful because of the ingrained dysfunctional ways of thinking and behaving. It is more useful to help the client with changing dysfunctional behaviors. Although milieu management is a component of care, the client usually is proficient in manipulation of the environment to meet his needs.

 CN: Psychosocial integrity; CL: Synthesize

4. 3. For this client, the nurse needs to use a calm, matter-of-fact approach to create a nonthreatening and secure environment because the client is experiencing problems with suspiciousness and trust. Use of “I” statements and responses would be therapeutic to reduce the client's suspiciousness and increase his trust in the staff and the environment. An authoritarian approach is nontherapeutic and inappropriate because the client may perceive this approach as an attack, subsequently responding with anger and threatening behavior. A parental or controlling approach may be perceived as authoritarian, and the client may become defensive and angry.

 CN: Safety and infection control; CL: Synthesize

5. 4. Attending an activity with the nurse assists the client to become involved with others slowly. The client with a schizotypal personality disorder needs support, kindness, and gentle suggestion to improve social skills and interpersonal relationships. The client commonly has problems in thinking, perceiving, and communicating and appears similar to clients with schizophrenia except that psychotic episodes are infrequent and less severe. Participation solely

in group activities or leading a sing-along would be too overwhelming for the client, subsequently increasing the client's anxiety and withdrawal. Engaging primarily in one-to-one activities would not be helpful because of the client's difficulty with social skills and interpersonal relationships. However, activities with the nurse could be used to establish trust. Then the client could proceed to activities with others.

 CN: Psychosocial integrity; CL: Synthesize

6. 2. The nurse needs to set limits on the client's manipulative behavior to help the client control dysfunctional behavior. The manipulative client bends rules to have her needs met without regard for rules or the needs or rights of others. A consistent approach by the staff is necessary to decrease manipulation. Ignoring the client's behavior reinforces or promotes the continuation of the client's manipulative behavior. Reprimanding the client may be perceived as a threat, resulting in aggressive behavior. Allowing the client to keep a snack in her room reinforces the dysfunctional behavior.

 CN: Psychosocial integrity; CL: Synthesize

7. 2. The nurse assists the client with identifying and putting feelings into words during one-to-one interactions. This helps the client express her feelings in a nonthreatening setting and avoid directing anger toward other clients. A client with an antisocial personality disorder needs to understand how others feel and react to her behaviors and why they react the way they do. The client also needs to understand the consequences of her behaviors. Using humor or indirect behaviors to express anger is a passive–aggressive method that will not help the client learn how to express her anger appropriately. Asking the nurse for medication when upset is a way to avoid dealing with feelings and is not helpful. However, medication may be necessary if talking and engaging in a physical activity have not been effective in lowering anxiety or if the client is about to lose control of her behavior.

 CN: Psychosocial integrity; CL: Synthesize

8. 1, 3, 4, 6. Inflexibility, need to be in control, perfectionism, overemphasis on work or tasks, and a fear of making mistakes are common symptoms of OCPD. Anafranil and Prozac may help with the obsessive symptoms, Interrupting the client's tasks is likely to increase her anxiety even more. Telling her that she cannot expect the family to be perfect is likely to create a power struggle.

 CN: Psychosocial integrity; CL: Apply

9. 1, 2, 4, 5. A professional, matter-of-fact approach and developing trust are the most effective with this client. A friendly approach, intrusiveness, and attempting to counteract the client's beliefs will increase the client's paranoia; he will present more false beliefs to prove he is right about the conspiracy. In groups, questions from peers, confrontations with reality, and the emotionality will increase the client's anxiety.

CN: Management of care; CL: Analyze

10. 4. Some characteristics of a client with a dependent personality are an inability to make daily decisions without advice and reassurance and the preoccupation with fear of being alone to care for oneself. The client needs others to be responsible for important areas of his life. The nurse should respond, "Your parents have been supportive of you and will continue to be supportive even if you live apart," to gently challenge the client's fears and suggest that they may be unwarranted. Stating, "You're a 28-year-old adult now, not a child who needs to be cared for," or "Your parents need a break, and you need a break from them," is reprimanding and would diminish the client's self-worth. Stating, "Your parents won't be around forever; after all they are getting older," may be true, but it is an insensitive response that may increase the client's anxiety.

CN: Psychosocial integrity; CL: Apply

11.

1. Monitor for suicide and self-mutilation.
3. Monitor sleeping and eating behaviors.
2. Discuss the issues of loneliness and emptiness.
4. Discuss her housing options for after discharge.

Safety is the priority concern and then eating and sleeping patterns need to be reestablished. After intervening to meet basic needs, delving into the loneliness and emptiness are important for determining underlying issues that need to be followed up in outpatient counseling. Although the client is living with her family currently, other options might be appropriate for her to consider.

CN: Safety and infection control; CL: Synthesize

12. 4. For the client with attention-seeking behaviors, the nurse would institute a behavioral contract with the client to help decrease dysfunctional behaviors and promote self-sufficiency. Having the client approach only his assigned staff person sets limits on his attention-seeking behavior. Telling the client to stay in his room until staff approach him, limiting the client to a certain area, or giving the client a list of permissible requests is punitive and does nothing to help the client gain control over the dysfunctional behavior.

 CN: Management of care; CL: Synthesize

13. 2. The most therapeutic response is, “All of the nurses here provide good care.” This statement corrects the client's unrealistic and exaggerated perception. “Splitting,” defined as the inability to integrate good and bad aspects of an individual and the self, is a hallmark behavior of a client with borderline personality disorder. The client sees himself and others as all good or all bad. Components of “splitting” include behaviors that idealize and devalue others. It is a defense that allows the client to avoid pain and feelings associated with past abuse or a current situation involving the threat of rejection or abandonment. The other statements promote the client's idealistic view and do nothing to help correct the client's distortion.

 CN: Psychosocial integrity; CL: Apply

14. 4. The client with borderline personality disorder is usually in a crisis situation when hospitalized for self-mutilation and suicidal ideation or behavior. The statement, “Any attempt at self-harm is serious and safety is a priority,” is the best response because the misperception that self-mutilation is used to gain attention can result in death of the client. The client can accidentally commit suicide. Any form of self-harm is an indication that the client needs treatment. The statement, “She's here now and we have to do our best,” is not helpful and does not educate the staff member about the client's needs. The statement, “She needs to be here until she can control her behavior,” may be true but does not provide information about the client's priority needs. The statement, “I'm ashamed of you; you know better than to say that,” is punitive, diminishes self-worth, and may not be a correct assumption of the staff member's knowledge.

 CN: Management of care; CL: Synthesize

15. 2. For the client who is at risk for self-mutilation, the nurse develops a contract to assist the client with assuming responsibility for his behavior and to help the client develop adaptive methods of coping with feelings. Self-mutilation is usually an expression of intense anxiety, anger, helplessness, or guilt or a means to block psychological pain by inducing physical pain. A typical contract

helpful to the client would have the client notify staff when anxiety is increasing. Withdrawing to his room when feeling overwhelmed, suppressing feelings when angry, or displacing feelings onto the primary health care provider is not an adaptive method to help the client deal with his feelings and could still result in self-mutilation.

 CN: Safety and infection control; CL: Evaluate

16. 4. Any suicidal statement must be assessed by the nurse. The nurse should discuss the client's statement with her to determine its meaning in terms of suicide, overwhelming feelings of anxiety, abandonment, or other need that the client cannot express appropriately. It is not uncommon for a client with borderline personality disorder to make threatening comments before discharge. Extending the hospital stay is inappropriate because it would encourage dependency and manipulation. Ignoring the client's statement on the assumption that it is a sign of manipulation is an error in judgment. Asking a family member to stay with the client temporarily at home is not appropriate and places the responsibility for the client on the family instead of the client.

 CN: Psychosocial integrity; CL: Synthesize

17. 4. The best initial course of action when admitting a client is to observe him to establish baseline information. This assessment provides valuable information about the client's behavior and forms the basis for the plan of care. Telling the client that the staff has authority to subdue him if he gets unruly or that he will have to pay for any damage he causes is threatening and may incite or provoke trouble. Isolating a client is not recommended unless there is a very good reason for it, such as a very active, combative client who is dangerous to himself and others.

 CN: Psychosocial integrity; CL: Synthesize

18. 4. The best response is, “You say you're not a regular here, but you're experiencing what others are experiencing.” This statement helps the client to identify factors that precipitate denial by helping her to confront that which inhibits compliance. Denial is used to help a client feel better and more secure when a situation provokes a high level of anxiety and is threatening to the client. The statement, “Because you're not a regular client, sit in the hall when the others are in group,” agrees with and promotes denial in the client and interferes with treatment. The statement, “Your family wants you to attend and they will be disappointed if you don't,” causes the client to feel guilty and decreases her self-esteem. The statement, “I'll have to mark you absent from the clinic today and speak to the doctor about it,” is punitive and threatening to the client,

subsequently decreasing her self-esteem.

CN: Psychosocial integrity; CL: Synthesize

19. 3. Stating, “I will not continue to talk with you if you curse,” sets limits on the client's behavior and points out the negative effects of her behavior. Therefore, this response is most appropriate and therapeutic. The statement, “You're being very childish,” reprimands the client, possibly causing the anger to escalate. The statement, “I'm sorry if you can't wait,” fails to provide feedback to the client about her behavior. The statement, “Come back tomorrow and your medication will be ready,” ignores the client's behavior, failing to provide feedback to the client about the behavior. It also shows poor nursing judgment because the client may need her medication before tomorrow or may not return to the clinic the following day.

CN: Psychosocial integrity; CL: Synthesize

20. 1. The client with avoidant personality disorder is showing signs of improvement when interacting with two other clients. A client with avoidant personality disorder is timid, socially uncomfortable, withdrawn, and hypersensitive to criticism. Social contact with others decreases isolation and withdrawal. Listening to music with headphones, sitting at a table and painting, and talking on the telephone are solitary activities and therefore do not indicate improvement, which is evidenced by social contact.

CN: Psychosocial integrity; CL: Analyze

21. 4. The priority is to explain to the client that this information has to be shared immediately with the staff and the primary health care provider because of its serious nature. Safety of all is crucial regardless of whether the client follows through on his plan. It is possible that the client is asking to be stopped and that he is indirectly pleading for help in a dysfunctional manner. Bargaining with the client, such as warning him that his telephone privileges will be taken away if he abuses them or offering to disregard his plan if he does not go through with it, is inappropriate. Saying nothing to anyone until the client has actually completed the call and then notifying the proper authorities represent serious negligence on the part of the nurse.

CN: Safety and infection control; CL: Synthesize

22. 1. The most basic and important idea to convey to a client is that, as a person, he or she is accepted, although his or her behavior may not be. Empathy is conveyed for emotional pain regardless of the client's behavior. Although some clients need limits placed on their behavior, not all clients require limit

setting. That the staff members are the primary ones left to care about these clients is not necessarily true, nor is it true that the staff should use very little humor with these clients. Clients who are rigid and perfectionists and who have a restricted affect may need help with displaying humor.

CN: Management of care; CL: Apply

23. 1. The nurse should explain the negative reactions of others toward the client's behaviors to make him aware of the impact of his seductive behaviors on others. Suggesting that the client apologize to others for his behavior is futile because the client cannot feel remorse for wrongdoing. Asking him to explain reasons for his seductive behavior is not helpful because this client is skillful at using projection and rationalization. Discussing his relationship with his mother is not helpful because the focus should be oriented to the present situation and managing his behavior at the present time.

CN: Psychosocial integrity; CL: Synthesize

24. 2. The nurse would specifically use supportive confrontation with the client to point out discrepancies between what the client states and what actually exists to increase responsibility for self. Limit setting and consistency also may be used. However, limit setting helps the client control unacceptable behavior and consistency helps reduce the frequency of negative behaviors; they do not point out discrepancies. Rationalization is typically used by the client, not the nurse, to blame others, make excuses, and provide alibis for self-centered behaviors.

CN: Psychosocial integrity; CL: Synthesize

25. 4. The nurse should use role playing to teach the client appropriate responses to others in various situations. This client dramatizes events, draws attention to self, and is unaware of and does not deal with feelings. The nurse works to help the client clarify true feelings and learn to express them appropriately. Party planning, music group, and cooking class are therapeutic activities, but will not help the client specifically learn how to respond appropriately to others.

CN: Psychosocial integrity; CL: Synthesize

The Client with an Alcohol-Related Disorder

26. 4, 5. As with any dementia, there is a need to protect the client from wandering off and risking harm to self. Dementia is progressive and eventually requires 24-hour supervision. Destroying the alcohol is notably ineffective; the client will find a way to get more if quitting is not a personal goal. Not

answering the client's question will generally increase the client's anger. Once the dementia is evident, lack of alcohol intake will not reverse the condition.

 CN: Psychosocial integrity; CL: Create

27.

2. “I hear how confused and frustrated you are.”

3. “It can happen that as one person sobers up, the spouse deteriorates.”

4. “What have you tried to do about your husband's behaviors?”

1. “What do you think you could do to have your husband come in for an evaluation?”

The client's feelings and concerns need to be validated, so that she will open up more. She also should know that the changes in her husband are not unusual. It helps to know the client has tried with her husband to determine if they are appropriate or not. Then there can be a discussion about getting help for her husband, so that her efforts to stay sober are not compromised.

 CN: Reduction of risk potential; CL: Analyze

28. 4. The best action by the nurse to help a client who has difficulty falling asleep would be to teach the client relaxation exercises to use before bedtime to reduce anxiety and promote relaxation. This activity will also be useful for the client when out of the hospital. Inviting the client to play a board game is inappropriate because this activity can be competitive and thus stimulate the client. Allowing the client to sit in the community room until she feels sleepy is inappropriate because it does nothing to help the client relax; nor does advising the client to sleep on the sofa in the dayroom, which may be against unit policy.

 CN: Basic care and comfort; CL: Synthesize

29.

4. Place client in a quiet room with dimmed lights.

1. Administer lorazepam 2 mg IM

2. Draw blood for a magnesium level.

3. Take vital signs every 15 minutes.

The nurse should first place the client in a quieter, darkened room with dimmer lights to decrease the stimuli from the busy emergency department (ED) and create a more calming environment. Next, the nurse should administer the lorazepam to help decrease agitation and reduce the risk of seizures. Drawing the blood will be easier as the client becomes less agitated. Depending on the magnesium blood level, the client may need an intramuscular (IM) dose of magnesium sulfate to prevent seizures. The nurse can then obtain the vital sign every 15 minutes to determine if the client is becoming stabilized and if the client needs further doses of lorazepam.

 CN: Management of care; CL: Synthesize

30. 1. The nurse should first contact the primary health care provider. The client's vital signs and level of consciousness are deteriorating, indicating complications of withdrawal, which can be life threatening. Increasing the rate of the infusion may cause fluid overload and has not been prescribed by the primary health care provider. Arousing the client will not address the underlying problems. Magnesium sulfate is used to treat seizures precipitated by alcohol withdrawal, but the client is not demonstrating signs of actual or impending seizures.

 CN: Safety and infection control; CL: Synthesize

31. 4. The nurse should provide the client with a quiet room to sleep in. Alcohol is destroyed and oxidized in the body at a slow, steady rate. The rate of alcohol metabolism is not influenced by drinking black coffee, walking around the unit, or taking a cold shower. Therefore, it is best to have the client sleep off the effects of the alcohol.

 CN: Reduction of risk potential; CL: Synthesize

32. 1, 2, 4, 5. For the client experiencing symptoms of alcohol withdrawal, the nurse monitors vital signs and intake and output, reinforces reality for the client who is confused, disoriented, or hallucinating, explains that the symptoms of withdrawal are temporary, reduces stimulation, and stays with the client if he

is confused or agitated. The nurse administers medications to prevent the progression of symptoms, such as seizures and delirium tremens, and to ensure the client's safety. Restraints are not used as a precautionary measure. Restraints are used only as a least restrictive measure to protect the client and others when the client is a danger to himself or others.

 CN: Psychosocial integrity; CL: Synthesize

33. 1, 3, 4, 5. Two or three days after cessation of alcohol, clients may experience delirium tremens (DTs), as evidenced by disorientation, nightmares, abdominal pain, nausea, and diaphoresis, as well as elevated temperature, pulse, and blood pressure, and visual and auditory hallucinations. If the client had a traumatic brain injury after falling, the client might have paralysis, but there is no association of paralysis from DTs.

 CN: Physiologic adaptation; CL: Synthesize

34. 3. The nurse should first confirm that the client has stopped taking the clonazepam because the client is reporting symptoms of benzodiazepine withdrawal from stopping the clonazepam abruptly. The client would report symptoms of being sedated if he took alcohol with the clonazepam. Tolerance symptoms would be increased anxiety, not these physical symptoms. Clonazepam is an appropriate medication for panic attacks, but taking extra pills without primary health care provider approval is not appropriate.

 CN: Pharmacological and parenteral therapies; CL: Analyze

35. 4. Antiseptic mouthwash commonly contains alcohol and should be kept in a locked area unless labeling clearly indicates that the product does not contain alcohol. A client with an intense craving for alcohol may drink mouthwash that contains alcohol. Personal care items, such as toothpaste, dental floss, and shaving cream, do not contain alcohol, and the client would be allowed to keep them in the room.

 CN: Safety and infection control; CL: Synthesize

36. 4. The best way to intervene with a client's minimization or denial of alcohol problems is to point out the consequences of the drinking—the multiple arrests. The other responses are superficial and discount the seriousness of the client's problem.

 CN: Psychosocial integrity; CL: Synthesize

37. 2. The client's response helps the nurse determine the severity of withdrawal symptoms because the length and extent of drinking alcohol has an effect on the severity of symptoms the client experiences during withdrawal.

Decreased use of alcohol can also result in withdrawal symptoms in the client who has developed a high tolerance to alcohol and is physically dependent. The severity of the disease, the possibility of hallucinations, and the occurrence of delirium tremens are not determined by the information given. The Axis I diagnosis of alcohol dependency is just that—it is not classified as mild, moderate, or severe. Alcoholic hallucinosis is a state of auditory hallucinations that develops about 48 hours after the client has stopped drinking. The client hears voices or noises within the context of a clear sensorium, meaning that the auditory hallucination is the only symptom the client experiences. Severe withdrawal symptoms that are not managed medically can progress to delirium tremens or a severe abstinence syndrome. Delirium tremens occurs about 3 to 5 days after the client's last drink and is characterized by confusion, agitation, severe psychomotor activity, hallucinations, sleeplessness, tachycardia, elevated blood pressure, elevated temperature, and possibly seizures.

 CN: Reduction of risk potential; CL: Analyze

38. 2. The nurse would most likely administer a benzodiazepine, such as lorazepam, to the client who is experiencing symptoms of alcohol withdrawal. The benzodiazepine substitutes for the alcohol to suppress withdrawal symptoms. The client experiences symptoms of withdrawal because of the “rebound phenomenon” when sedation of the central nervous system (CNS) from alcohol begins to decrease. Haloperidol (Haldol) is an antipsychotic and is not indicated for alcohol withdrawal symptoms. Benztropine is used to treat extrapyramidal symptoms associated with antipsychotic therapy. Naloxone is used in opioid overdose to reverse the CNS depression caused by the opioid.

 CN: Pharmacological and parenteral therapies; CL: Apply

39. 3. Monitoring vital signs provides the best information about the client's overall physiologic status during alcohol withdrawal and the physiologic response to the medication used. Vital signs reflect the degree of central nervous system irritability and indicate the effectiveness of the medication in easing withdrawal symptoms. Although assessment of nutritional status and sleep pattern and assessment for evidence of tremors are important, they provide only indirect information about single aspects of the client's physiologic status.

 CN: Reduction of risk potential; CL: Analyze

40. 1. A client is suffering from a blackout when he cannot recall what he did while under the influence of alcohol. A hangover refers to symptoms experienced the day after a bout of heavy drinking. Common symptoms include headaches and gastrointestinal distress, typically after heavy alcohol

consumption. Tolerance refers to the need to increase the amount of the substance or to ingest the substance more often to achieve the same effects. Delirium tremens refers to severe alcohol withdrawal or abstinence syndrome with confusion, psychomotor agitation, sleeplessness, hallucinations, and elevated vital signs.

 CN: Physiological adaptation; CL: Analyze

41. 4. Stating, “I'm Maria, a nurse in the program; the staff and I will help you,” is a nonjudgmental, caring approach that promotes trust and a therapeutic relationship. The statement, “I hope you are serious about maintaining your sobriety this time,” blames the client, subsequently decreasing the client's self-worth. Saying, “You'll get it right this time” is threatening to the client, possibly leading to decreased self-worth by reinforcing the client's past failures at maintaining sobriety. The statement, “I know someone who was successful after the fifth program,” is impersonal and irrelevant to the client's situation.

 CN: Psychosocial integrity; CL: Synthesize

42. 3. The wife of the man with alcohol dependency is exhibiting enabling behavior when she makes excuses for her husband's absenteeism. Enabling behavior is not helpful to the client but rescues him from adverse consequences in relation to his employment. Self-defeating behavior would be evidenced by putting oneself in a position that will lead to failure. Masochistic behavior would be evidenced by the need to experience emotional or physical pain to become sexually aroused.

 CN: Psychosocial integrity; CL: Analyze

43. 4. To be most helpful, the nurse should calmly and objectively present facts by saying, “You have alcohol on your breath,” to help the coworker overcome denial and resistance. This statement also helps to reinforce the coworker's awareness of the problem. The other statements blame the coworker and may reinforce denial. Blaming, nagging, and yelling diminish self-esteem in the individual with a substance abuse problem who has low frustration tolerance.

 CN: Psychosocial integrity; CL: Synthesize

44. 3. The nurse leader should direct the husband to say, “Either you get help or the kids and I will move out of the house.” This statement facilitates entrance into treatment because it is a direct statement of what the consequences are if the alcohol abuse continues. The statement, “The children and I want you to get help,” is not effective. Most likely, the husband has already made a similar statement before the confrontation session. Saying, “If your parents were alive,

they would be extremely disappointed in you," or "You need to enter treatment now or be a drunk if that's what you want," shames the wife and further decreases her self-esteem.

CN: Management of care; CL: Synthesize

45. 3. The statement, "You interrupted Terry twice in 4 minutes," indicates an understanding of the use of constructive feedback by describing specifically what was seen and heard in an objective manner. The other statements are judgmental and blame the client without specifying what the objectionable behavior is.

CN: Psychosocial integrity; CL: Evaluate

46. 4. The client is feeling remorse about hitting his wife. It is best to make a comment that will help him focus on his feelings and express them. Reflecting what the client has said is a good technique to accomplish these goals. Suggesting the client ask his wife or explore the issue in family therapy is inappropriate because it gives advice and ignores the client's underlying feelings. Saying "It would depend on how much she really cares for you" is inappropriate because it ignores the client's feelings and reinforces the negative aspects, such as the shamefulness, of the behavior.

CN: Psychosocial integrity; CL: Synthesize

47. 2. Al-Anon is a self-help group for spouses and significant others that provides education and support and helps participants learn to lead their own life without feeling responsible for the individual with an alcohol problem. Alateen provides support for teenaged children of a person with an alcohol problem. Employee assistance programs help employees recover from alcohol or drug dependence while retaining their positions or jobs. Alcoholics Anonymous provides support for the individual with alcohol problems to attain and maintain sobriety.

CN: Management of care; CL: Apply

48. 1. Having the client who is experiencing severe symptoms of alcohol withdrawal walk is contraindicated because increased activity and stimulation may confuse the client and promote hallucinations. The client may also sustain an injury if he has a seizure as part of the alcohol withdrawal process. The nurse should monitor intake and output to ensure fluid and electrolyte balance and hydration. The nurse should assess vital signs to assess the physiologic status of the client and the response to medications. The nurse should use short, concrete statements to decrease confusion and ambiguity.

CN: Reduction of risk potential; CL: Apply

49. 1. Any amount of alcohol consumed while taking disulfiram (Antabuse) can cause an alcohol-disulfiram reaction. The reaction experienced is in proportion to the amount of alcohol ingested. The alcohol-disulfiram reaction can begin 5 to 10 minutes after alcohol is ingested. Symptoms can be mild, as in flushing, throbbing in the head and neck, nausea, and diaphoresis. Other symptoms include vomiting, respiratory difficulty, hypotension, vertigo, syncope, and confusion. Severe reactions involve respiratory depression, convulsions, coma, and even death. Disulfiram can be taken at bedtime if the client feels sleepy from the medication. Some clients experience a metallic or garlic taste when initiating disulfiram treatment. Anything containing alcohol, such as cough medicine, aftershave lotion, and mouthwash, can cause a reaction. Therefore, the client needs to check the labels of these items for their alcohol content.

CN: Pharmacological and parenteral therapies; CL: Evaluate

50. 3. The first question should be to ask the client how much alcohol she has had today because nausea with severe vomiting is a sign of an alcohol-disulfiram (Antabuse) reaction. Asking the client whether she feels like she has flu symptoms is important after inquiring about alcohol intake. Foods cooked in an alcoholic beverage, such as wine, could also cause a reaction, but the reaction would be less severe because the alcohol dissipates with cooking. Asking how long the client has been taking Antabuse would be least important at this time.

CN: Pharmacological and parenteral therapies; CL: Synthesize

51. 1. Thiamine specifically prevents the development of Wernicke's encephalopathy, a reversible amnestic disorder caused by a diet deficient in thiamine secondary to poor nutritional intake that commonly accompanies chronic alcoholism. It is characterized by nystagmus, ataxia, and mental status changes. Because the client would rather drink alcohol than eat, the client is depleted of vitamins and nutrients. Alcohol also is an irritant that causes a “malabsorption syndrome” in which vitamins and nutrients are not absorbed properly in the gastrointestinal tract. Thiamine is not associated with decreasing withdrawal symptoms, helping clients regain their strength, or promoting elimination of alcohol from the body.

CN: Pharmacological and parenteral therapies; CL: Apply

52. 2. The statement, “Stopping AA and not expressing feelings can lead to relapse,” indicates the client's understanding of signs of relapse. The client is

responsible for sobriety and must understand the signs of relapse. Other antecedents to relapse include severe craving, being around users, and severe emotional crises. The other statements place the responsibility for the client's sobriety on someone else.

 CN: Reduction of risk potential; CL: Evaluate

53. 1. The client is using denial, an unconscious defense mechanism, when she refuses to acknowledge that she has a problem with alcohol. This is further evidenced by the client's inability to connect the liver disorder with alcohol ingestion. Displacement involves transfer of a feeling to someone else or to an object. Rationalization involves an attempt to make or prove that one's feeling or behavior is justifiable. Reaction formation is a conscious behavior that is the exact opposite of an unconscious feeling.

 CN: Psychosocial integrity; CL: Analyze

54. 2. Regular coffee contains caffeine, which acts as a psychomotor stimulant and leads to feelings of anxiety and agitation. Serving coffee to the client may add to tremors and wakefulness. Milk, orange juice, and eggs are part of a well-balanced, high-protein diet needed by the client in alcohol withdrawal, who is nutritionally depleted.

 CN: Reduction of risk potential; CL: Apply

55. 4. The nurse should teach the client with peripheral neuropathy to avoid using an electric blanket because the client is likely to have decreased sensitivity in the extremities owing to the damaging effects of alcohol on the nerve endings. It is particularly important to guard against burns because the client may not be able to discern the appropriate degree of heat on the feet. Daily washing and drying, massaging with lotion, and trimming the toenails are appropriate foot care measures for any client.

 CN: Reduction of risk potential; CL: Create

56.

1. Remind the client that he is having withdrawal symptoms and that these will be treated.

4. Take the client's vital signs depending on the severity of the withdrawal symptoms.

3. Assess the client for other withdrawal symptoms.

2. Administer a dose of lorazepam (Ativan).

5. Chart the details of the episode on the electronic health record.

After the nurse reminds the client about this withdrawal symptom, the nurse should take the client's vital signs and then assess for other symptoms, such as visual and auditory disturbances, tremors, anxiety, nausea, and excess perspiration. The elevation of the vital signs also helps to determine the amount of Ativan needed to control the withdrawal symptoms. The nurse should then chart the details of the episode and outcomes of the interventions.

 CN: Physiological adaptation; CL: Synthesize

57. 3. The client with alcohol withdrawal delirium should not be left unattended when confused, disoriented, or hallucinating. Injury or unintentional suicide is a possibility when the client attempts to get away from hallucinations. Restraints are used only when the client loses control and is a danger to herself or others, to protect the client from injury or harm. Touching the client before saying anything is an additional stimulus that would most likely add to the client's agitation. Informing the client about the alcohol treatment program while the client is delirious is inappropriate and shows poor nursing judgment. The client should be given information about alcohol treatment when the withdrawal symptoms are lessening and the client can comprehend the information.

 CN: Safety and infection control; CL: Synthesize

58. 2. Alcoholics Anonymous (AA), a self-help program based on 12 steps, is open to anyone whose goal is sobriety. The first step requires that the individual admit that he is powerless over alcohol and needs help. Members are in various stages of recovery, and the individual does not have to be sober for at least a month before joining. Potential members are not interviewed. The individual decides how many meetings to attend each week. AA does not require attendance at meetings daily, but some individuals choose to do so, especially at the beginning of recovery.

 CN: Management of care; CL: Apply

59. 4. Follow-up care is essential to prevent relapse. Recovery has just begun when the treatment program ends. The first few months after program

completion can be difficult and dangerous for the chemically dependent client. The nurse is responsible for discharge plans that include arrangements for counseling, self-help group meetings, and other forms of aftercare. Supportive friends, a list of goals, and family forgiveness may be important and helpful to the client, but follow-up care is essential.

CN: Management of care; CL: Create

60. 2, 3, 4. The client who plans to attend Alcoholics Anonymous meetings, verbalizes the damaging effects of alcohol on his body, and takes naltrexone daily may be ready for alcohol rehabilitation. Other key outcomes include admitting that a problem with alcohol exists and realizing the negative effects of alcohol on his life. Stating that he needs to cut down on his alcohol intake and that he is indestructible are signs of denial of an alcohol problem.

CN: Management of care; CL: Evaluate

61. 3. The best approach is to treat both illnesses simultaneously. Treating one and not the other is ineffective. The depression will not clear just by becoming sober or clean.

CN: Management of care; CL: Synthesize

62. 2. The nurse should assess the client's mental status daily to note changes that could occur from exacerbation of the mental illness or withdrawal from alcohol. Changes in mental status are important for treatment issues such as medication and participation in groups. Assessment of mental status takes priority because mental status affects the client's ability to sleep, eat, and care for himself. Flexibility is necessary on the part of nurses and staff members who are working with a heterogeneous client population.

CN: Management of care; CL: Analyze

63. 1. The client's decision to drink results in feeling accepted by his peers which increases his self-esteem. Guilt or shame may result later because the client is aware that he should not use alcohol because of his mental illness. The combination of a mental illness and substance abuse results in increased recidivism and treatment complications. It may not be true that the client abused alcohol before developing a mental illness or that the client is compelled to drink because of cognitive difficulties. The client may be predisposed to developing a substance abuse problem and a mental illness because of heredity and biologic factors.

CN: Psychosocial integrity; CL: Apply

The Client with Disorders Related to Other Addictive Substances

64. 4. Tapering doses of oxycodone, pain management strategies, and other pain control medicines are found to be the most helpful with opiate addictions resulting from chronic pain. Nonaddictive (over-the-counter) medicines alone are generally insufficient for chronic pain management. Methadone is an addictive opioid that involves substituting one addiction with another, so now clients are being detoxed off Methadone as well. Lorazepam may help with anxiety during withdrawal from opiates, but it does not control the other symptoms of opiate withdrawal.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

65. 1, 4, 5, 6. The nurse should instruct the parents to monitor their children for use of paper bags or rags. The nurse should present information about brain damage from inhalants including damage to the frontal lobe, cerebellum, and hippocampus, and that death is possible. Rather than use being on the decline, teenagers are experimenting even more with many types of inhalants, such as Freon, ground-up candy disks, and spray cleaners for computer and TV screens.

 CN: Health promotion and maintenance; CL: Create

66. 1. A respiratory rate of less than 12 breaths/min is cause for concern because of central nervous system depression. Respiratory depression and arrest is the primary cause of death among clients who abuse opioids. Peripheral nervous system effects associated with opioid abuse include urinary retention, hypotension, reduced pupil size, constipation, and decreased gastric, biliary, and pancreatic secretions. Pinpoint pupils are a sign of opioid overdose. However, respiratory depression is the immediate concern.

 CN: Reduction of risk potential; CL: Analyze

67. 1, 2, 3. Symptoms of opioid withdrawal include yawning, rhinorrhea, sweating, chills, piloerection (goose bumps), tremors, restlessness, irritability, leg spasms, bone pain, diarrhea, and vomiting. Symptoms of withdrawal occur within 36 to 72 hours of usage and subside within a week. Withdrawal from heroin is seldom fatal and usually does not necessitate medical intervention. Synesthesia (a blending of senses) is associated with lysergic acid diethylamide use, and formication (feeling of bugs crawling beneath the skin) is associated with cocaine use.

 CN: Psychosocial integrity; CL: Analyze

68. 4, **5.** Naloxone is an opioid antagonist used to treat an opioid overdose. Within a few minutes, the client should have an increase of respirations to near normal and become conscious. With a heroin overdose, the pulse is not significantly affected, the skin becomes warm and wet, and the pupils are dilated. With naloxone the skin would return to a normal temperature and become dry. The pupils also would react normally and the pulse would not be decreased.

 CN: Pharmacological and parenteral therapies; CL: Analyze

69. 1. Vomiting and diarrhea are usually late signs of heroin withdrawal, along with muscle spasm, fever, nausea, repetitive sneezing, abdominal cramps, and backache. Early signs of heroin withdrawal include yawning, tearing (lacrimation), rhinorrhea, and sweating. Intermediate signs of heroin withdrawal are flushing, piloerection, tachycardia, tremor, restlessness, and irritability.

 CN: Reduction of risk potential; CL: Analyze

70. 4. After administering naloxone, the nurse should monitor the client's respiratory status carefully because the drug is short acting and respiratory depression may recur after its effects wear off. Cerebral edema, kidney failure, and seizure activity are not directly related to opioid overdose or naloxone therapy.

 CN: Pharmacological and parenteral therapies; CL: Analyze

71. 4. The client takes methadone primarily to be able to work, live normally, and function productively without the mental and physical deterioration caused by opioid addiction. Methadone lessens physiologic dependence on opioids and is used to prevent withdrawal symptoms. Methadone, a substance similar to morphine, is an addictive substance; the client is still considered addicted to opioids. Because methadone has a long half-life of 15 to 30 hours, it can be taken once a day on an outpatient basis.

 CN: Psychosocial integrity; CL: Apply

72. 1. Suggesting that the client try attending a meeting at a different location is a supportive, positive response and encourages the client to continue participating in treatment. Saying, “Maybe it just wasn't a good day for you,” or “Perhaps you weren't paying close enough attention,” places blame on the client and is not helpful. The statement, “Sometimes the meetings can seem like a waste of time, but you need to attend to stay clean,” diminishes the importance of the self-help group and offers little support to the client.

 CN: Management of care; CL: Synthesize

73. 2. The best measure to determine a client's progress in rehabilitation is the number of drug-free days he has. The longer the client abstains, the better the prognosis is. Although the kinds of friends the client makes, the way he gets along with his parents, and the degree of responsibility his job requires could influence his decision to stay clean, the number of drug-free days is the best indicator of progress.

 CN: Physiological adaptation; CL: Evaluate

74. 4. The client who is addicted to heroin is most likely to exhibit hypoactivity. Initially, the client feels euphoric. This is followed by drowsiness, hypoactivity, anorexia, and a decreased sex drive. Hilarity, aggression, and a labile mood usually are not associated with heroin addiction.

 CN: Psychosocial integrity; CL: Analyze

75. 4. Because barbiturates are central nervous system depressants, the nurse should be especially alert for the possibility of respiratory failure. Respiratory failure is the most likely cause of death from barbiturate overdose. Kidney failure, cerebrovascular accident, and status epilepticus are not associated with barbiturate overdose.

 CN: Reduction of risk potential; CL: Analyze

76. 4. When a friend asks whether a seriously ill client will live, it is best for the nurse to respond by explaining the seriousness of the client's condition and acknowledging the friend's concern. This type of comment does not offer false hope. Telling the friend to wait and see and that it is too soon to tell is a stereotypical statement that offers no support to the friend. Asking the friend to describe his or her relationship with the client ignores the friend's concern and does not focus on the problem. Simply saying that the client is very ill and may not live and that some don't pull through is harsh and not supportive.

 CN: Psychosocial integrity; CL: Synthesize

77. 1. Tolerance for a drug occurs when a client requires increasingly larger doses to obtain the desired effect. Therefore, the plan of care would address the client's state of tolerance. The term addiction refers to psychological and physiologic symptoms indicating that an individual cannot control his or her use of psychoactive substances. This term has been replaced with the term dependence. Abuse refers to the excessive use of a substance that differs from societal norms. Drug dependence occurs when the client must take a usual or increasing amount of the drug to prevent the onset of abstinence symptoms, cannot keep drug intake under control, and continues to use even though

physical, social, and emotional processes are compromised.

 CN: Physiological adaptation; CL: Analyze

78. 4. For a client who is confused when awakening after taking a large dose of barbiturates, the nurse should speak in concrete terms using simple statements in a calm, nonjudgmental, gentle manner to assist the client with cognitive-perceptual impairment, enhance understanding, and decrease anxiety. The other statements contain abstract information and some slang terms that may further confuse the client and thus increase the client's anxiety.

 CN: Psychosocial integrity; CL: Synthesize

79. 2. The highest priority is assessing for suicide risk. When the client is safe, then the self-esteem, helplessness, and hopelessness issues can be addressed.

 CN: Psychosocial integrity; CL: Synthesize

80. 1. The most appropriate initial outcome for the client is to discuss thoughts and feelings related to her losses. The nurse should help the client identify and verbalize her feelings so that she can externalize her thoughts and emotions and begin to deal with them. This prevents the client from internalizing feelings, which leads to depression and self-harm. The ability to identify two positive qualities, explore strengths, and prioritize problems would be appropriate after the client has explored her thoughts and feelings, gained awareness of the issues, and then can participate in the treatment plan.

 CN: Psychosocial integrity; CL: Evaluate

81. 4. The best method to deal with the problem is to discuss observations with clients at the daily community meeting because the problem involves all of the clients and this provides them with the opportunity to offer their views. Peer pressure is valuable in confronting self-defeating and destructive behaviors. Providing additional recreation avoids or ignores the problem and is damaging to all clients because it decreases trust in the nurse. Breaking up drug-oriented discussions would not be sufficient to stop the behavior. Speaking with the clients individually about their behavior is not as effective as dealing with the problem openly and directly with everyone.

 CN: Psychosocial integrity; CL: Synthesize

82. 4. The nurse directs the conversation to realistic concerns or issues to decrease denial and focus on rebuilding a substance-free life. Allowing the client to continue with the stories or questioning the client further about her exploits reinforces the denial. Telling the client you've heard the stories before is

nondirective. Additionally, these actions do nothing to help the client focus on rebuilding a substance-free life.

CN: Psychosocial integrity; CL: Synthesize

83. 3. The statement that marijuana causes more damage to your body than regular cigarettes is a direct, correct, educational response to the student's statement that does not decrease the student's or the friend's self-worth. Marijuana causes harmful pulmonary effects, weakens heart contractions, causes immunosuppression, and reduces serum testosterone and sperm count. Telling the student that marijuana is unsafe and illegal, or that using marijuana leads to using other chemicals, does not provide the student with factual information to answer the student's question. Asking whether the student really believes the friend challenges the student and may lead to defensive behavior.

CN: Psychosocial integrity; CL: Apply

84. 1, 2, 4, 5. Ecstasy is chemically related to methamphetamine (speed) and is used at all-night parties also known as “raves” to enhance dancing, closeness to others, affection, and the ability to communicate. Euphoria, heightened sexuality, disinhibition, and diminished self-consciousness can occur. Adverse effects include tachycardia, elevated blood pressure, anorexia, dry mouth, and teeth grinding. Pacifiers, including candy-shaped pacifiers and lollipops, are used to ease the discomfort associated with teeth grinding and jaw clenching. Hyperthermia, dehydration, renal failure, and death can occur.

CN: Reduction of risk potential; CL: Create

85.

3. Confirm with the client that she has in fact been using her husband's medications.
4. Assess the client for prior and current use of any other substances.
2. Immediately place the client on withdrawal precautions.
1. Call the physician for prescriptions for appropriate treatment for opiate and benzodiazepine withdrawal.

It crucial to confirm that the client was taking her husband's opiates and benzodiazepines and that her symptoms are due to the sudden withdrawal from these medications. It is also important to know if she has been using other substances (such as alcohol) that may cause other withdrawal symptoms. Even before calling the physician for prescriptions, the nurse can initiate withdrawal precautions for client safety.

 CN: Safety and infection control; CL: Apply

86. 4. Acknowledging the client's son's feelings is the most therapeutic intervention because he is not likely to hear the nurse's information until his anger and other feelings are addressed and subside. Then it is important to acknowledge that oxycontin, especially in older clients, can interfere with remembering how many pills were taken. It is common for clients with chronic pain to inadvertently overuse or become addicted to pain medications. Pain management programs help clients to withdraw from the offending medication and start on a multifaceted system for controlling the pain.

 CN: Psychosocial integrity; CL: Create

87. 1, 2, 3, 5. Clients who deny an addiction and the need for treatment can be at risk for a suicide attempt, efforts to escape the unit, and aggression directed at staff. A contraband search is a safety measure to look for concealed drugs and dangerous items. Depending on the last use of the substance, withdrawal symptoms can begin quickly. A urine drug screen is crucial to determine what other substances the client may be using that may cause other withdrawal symptoms. Explaining the unit routines and groups can wait until the client is calmer and more receptive.

 CN: Safety and infection control; CL: Analyze

88. 2, 3, 5. The dose, length of use, and the number of Valiums taken per day are important for assessing the severity of the substance abuse and potential withdrawal. Determining sleep interferences is necessary for treating the underlying causes of the insomnia. The reason his wife takes Valium is confidential information and not critical to his situation. Getting off the Valium is essential, not an option, especially with his cardiac issues. This needs to be done safely if he has been taking it for more than a week or 2.

 CN: Psychosocial integrity; CL: Analyze

89. 2, 3, 4, 5, 6. The cocaine was not swallowed, so inducing vomiting is not indicated. A cocaine overdose can produce seizures, paranoia, and respiratory and/or metabolic acidosis. Deep breathing will help decrease the respiratory

distress and pulse rate.

CN: Pharmacological and parenteral therapies; CL: Synthesize

90. 4. The nurse assesses the client for feelings of depression and suicidal ideation. After experiencing an instantaneous high from crack, a crash immediately follows and the client has an intense craving for more crack. A crash commonly leads to a cocaine-induced depression when additional crack is unavailable. At times, the depression is so severe that users attempt suicide. Although suspiciousness, loss of appetite, and drug craving are also associated with cocaine use, they are less of a priority than suicidal ideation.

CN: Psychosocial integrity; CL: Analyze

91.

3. Place seizure pads on the bed.
2. Monitor cardiac and respiratory status.
4. Administer IM haloperidol (Haldol) as prescribed.
1. Transfer the client to the psychiatric unit.

The risk of seizures is an immediate safety issue, and the nurse should first place seizure pads on the bed. Amphetamine overdose can produce cardiac arrhythmias and respiratory collapse; the nurse should next monitor the client. Then the Haldol is indicated to antagonize the amphetamine affects. When the client is medically stable, the nurse can transfer the client to a psychiatric unit. Haldol would be stopped as the psychotic symptoms subside.

CN: Reduction of risk potential; CL: Synthesize

92. 2. Ativan, as opposed to Xanax, is available in dosage ranges that allow more gradual tapering down of doses over the 3 to 4 days. Haldol is not effective for benzodiazepine withdrawal. Tapering Xanax in 48 hours is too rapid. Offering Xanax as a PRN does not deal with the need to gradually reduce the dose and frequency over time.

CN: Pharmacological and parenteral therapies; CL: Synthesize

93. 1, 2, 5. The client is exhibiting symptoms of moderate anxiety. At this

level of anxiety, the nurse should help the client to decrease anxiety by allowing ventilation, crying, exercise, and relaxation techniques. The nurse would further assist the client by refocusing his attention, relating behaviors and feelings to anxiety, and then assisting with problem solving. Oral medication may be needed if the client's anxiety is prolonged or does not decrease with the nurse's interventions. Suggesting a time-out and giving intramuscular medication are possible interventions for a client whose anxiety level is severe.

 CN: Psychosocial integrity; CL: Synthesize

94. 2. The nurse must be especially cautious when providing care to a client who has taken phencyclidine (PCP) because of unpredictable, violent behavior. The client can appear to be in a calm state or even in a coma, then become violent, and then return to a calm or comatose state. Visual hallucinations, bizarre behavior, and loud screaming are associated with PCP-intoxicated clients. However, the unpredictable, violent behavior presents a major issue of safety for clients and staff.

 CN: Safety and infection control; CL: Analyze

95. 3. An acid environment aids in the excretion of PCP. Therefore, the nurse should give the client with PCP intoxication cranberry juice to acidify the urine to a pH of 5.5 and accelerate excretion.

 CN: Reduction of risk potential; CL: Synthesize

96. 1. Smoking marijuana while using alcohol can lead to alcohol poisoning because marijuana masks the nausea and vomiting associated with excessive alcohol consumption. Marijuana contains tetrahydrocannabinol (THC), which is responsible for suppressing nausea. With dangerous levels of alcohol in the body, respiratory depression, coma, and death can occur. Lysergic acid diethylamide, peyote, and psilocybin do not contain THC.

 CN: Reduction of risk potential; CL: Analyze

97. 3. Providing frequent “time-outs” when the client is highly anxious, sensitive, irritable, and over-reactive is needed to calm the client and reduce the possibility of escalating behaviors and violence. Secluding and restraining the client is not appropriate and would only be used if the client was threatening others and other alternative actions had been unsuccessful. Telling the client to stay in his room until he can control himself is unrealistic and futile because the client cannot eliminate behaviors induced by chemicals. Confronting the client about his behaviors would most likely lead to aggression and possibly violent behavior.

CN: Safety and infection control; CL: Synthesize

98. 4. The nurse should invite the client who is anxious to participate in an activity that involves gross motor movements. Doing so helps to direct energy toward a therapeutic activity. Appropriate activities include walking, riding a stationary bicycle, or playing volleyball. Assigning the client to an educational group is not helpful because the anxious client would be unable to sit in a group setting and concentrate on what was occurring in the group. Watching television may be too stimulating for the client, possibly increasing anxiety. Additionally, the client may be too anxious to sit and focus. Waiting for the client to approach the nurse is not helpful or appropriate. The nurse is responsible for initiating contact with the client.

CN: Psychosocial integrity; CL: Create

99. 1, 3, 4, 5. Since methadone is an addictive medication, the client will be gradually tapered off of it, while monitoring him for withdrawal symptoms. Any residual pain is likely to be controlled with other pain management techniques and nonnarcotic pain medication. It is very unlikely that oxycodone would be prescribed PRN since it is a very addictive medication.

CN: Reduction of risk potential; CL: Apply

100. 1, 2, 3, 4, 6. Acknowledgment of the client's frustration, pain, and cravings is important to decrease the client's anger. Naltrexone can help with detoxification from alcohol and opiates. Asking the physician about the possibility of adding naltrexone is appropriate. The nurse can never promise that a medication will help this client, since naltrexone is effective with only 20% to 30% of clients with opiate cravings.

CN: Pharmacological and parental therapies; CL: Analyze

The Client with Anxiety Disorders and Anxiety-Related Disorders

101. 2. The nurse cannot appear to take the side of either the student or her mother, so discussing the situation together where all points of view can be presented and evaluated is the best option. To avoid college altogether is likely to only escalate both parties' anxiety.

CN: Psychosocial integrity; CL: Apply

102. 4. The client's concerns are real and serious enough to warrant assessment by a physician rather than being dismissed as trivial. Though he is very intelligent, his intelligence cannot overcome his anxiety, and in fact, his

anxiety is likely to interfere with his ability to perform in college if no assessment and treatment is received. Just postponing college is likely to increase the client's anxiety rather than lower it since it does not address the panic he is experiencing.

 CN: Psychosocial integrity; CL: Analyze

103. 1, 2, 3, 5. Anger and rage could be directed at self and others. He implies that he did nothing wrong in assaulting the woman (denial) and may try to leave without treatment. A No Harm Contract is essential for everyone's safety. He needs safe outlets, including staff talks, for his anger. Talking about his views of prostitutes in unit groups may be upsetting to female clients who have sexual abuse issues as well, so this needs to occur in private.

 CN: Safety and infection control; CL: Create

104. 1, 4, 5. The nurse should instruct the client who is taking diazepam to take the medication as prescribed; stopping the medication suddenly can cause withdrawal symptoms. This medication is used for a short term only. The drug dose can be potentiated by alcohol and the client should not drink alcoholic beverages while taking this drug. Swelling of the lips and face and difficulty breathing are signs and symptoms of an allergic reaction. The client should stop taking the drug and seek medical assistance immediately. The client does not need to avoid eating foods containing tyramine; tyramine interacts with monoamine oxidase inhibitors, not Valium. The client can take the medication with food.

 CN: Health promotion and maintenance; CL: Synthesize

105. 4. Cognitive behavioral therapy is effective in treating anxiety disorders. The nurse can assist the client in identifying the onset of the fears that cause the anxiety and develop strategies to modify the behavior associated with the fears. Avoiding touching foods, asking about reasons for the anxiety, and providing ways to work around touching the foods do not deal with the anxiety and are not interventions that will help this client.

 CN: Psychosocial integrity; CL: Synthesize

106. 2. Asking, “Are you feeling anxious?” helps the client to specifically label the feeling as anxiety so that he can begin to understand and manage it. Some clients need assistance with identifying what they are feeling so they can recognize what is happening to them. Stating, “You need to sit down and relax,” is not appropriate because the client needs to continue his pacing to feel better. Asking if something is bothering the client or saying that he must be

experiencing a problem is vague and does not help the client identify his feelings as anxiety.

CN: Psychosocial integrity; CL: Synthesize

107. 1. The nurse responds with the statement, “It was very frightening for you,” to express empathy, thus acknowledging the client's discomfort and accepting his feelings. The nurse conveys respect and validates the client's self-worth. The other statements do not focus on the client's underlying feelings, convey active listening, or promote trust.

CN: Psychosocial integrity; CL: Synthesize

108.

4. Reduce environmental stimuli.
2. Ask the client to deep breathe for 2 minutes.
3. Discuss the client's feelings in more depth.
1. Teach problem-solving strategies.

Immediate anxiety-reducing strategies are to decrease stimuli and then do deep breathing. Once the anxiety is lessened, then the client's feelings can be explored for triggers and underlying issues. Then problem-solving strategies can be discussed to handle the triggers and issues appropriately.

CN: Psychosocial integrity; CL: Synthesize

109. 3. It is important for the nurse to teach the client that the symptoms of a panic attack are time limited and will abate. This helps decrease the client's fear about what is occurring. Clients benefit from learning about their illness, what symptoms to expect, and the helpful use of medication. A simple biologic explanation of the disorder can convince clients to take their medication. Telling the client to stay in the house to eliminate panic attacks is not correct or helpful. Panic attacks can occur “out of the blue,” and clients with panic disorder can become agoraphobic because of fear of having a panic attack where help is not available or escape is impossible. Medication should be taken on a scheduled basis to block the symptoms of panic before they start. Taking medication when

symptoms start is not helpful. Telling the client to maintain self-control to decrease symptoms of panic is false information because the brain and biochemicals may account for its development. Therefore, the client cannot control when a panic attack will occur.

CN: Psychosocial integrity; CL: Create

110. 1. Alprazolam, a benzodiazepine used on a short-term or temporary basis to treat symptoms of anxiety, increases gamma-aminobutyrate, a major inhibitory neurotransmitter. Because gamma-aminobutyric acid is increased and the reticular activating system is depressed, incoming stimuli are muted and the effects of anxiety are blocked. Alprazolam does not directly target serotonin, dopamine, or norepinephrine.

CN: Pharmacological and parenteral therapies; CL: Apply

111. 1, 2, 4, 5. It is appropriate to provide education on medication mechanisms, benefits, and managing side effects. No medication will eliminate all anxiety, so teaching about anxiety reduction and adaptive coping is needed. Effexor is a serotonin-norepinephrine reuptake inhibitor antidepressant and it will take 2 to 4 weeks to feel the effects.

CN: Pharmacological and parenteral therapies; CL: Create

112. 3. Using alcohol or any central nervous system depressant while taking a benzodiazepine, such as alprazolam, is contraindicated because of additive depressant effects. Ingestion of chocolate, cheese, or shellfish is not problematic.

CN: Pharmacological and parenteral therapies; CL: Apply

113. 1. Buspirone, a nonbenzodiazepine anxiolytic, is particularly effective in treating the cognitive symptoms of anxiety, such as worry, apprehension, difficulty with concentration, and irritability. BuSpar is not effective for the somatic symptoms of anxiety (muscle tension). Therapeutic effects may be experienced in 7 to 10 days, with full effects not occurring for 3 to 4 weeks. This drug is not known to cause physical or psychological dependence. It can be taken with food or small meals to reduce gastrointestinal upset.

CN: Pharmacological and parenteral therapies; CL: Evaluate

114. 2. The nurse initially reassures the client that her feelings and behaviors are typical reactions to serious trauma to help decrease anxiety and maintain self-esteem. Explaining the effects of stress on the body may be helpful later. Telling the client that her symptoms are temporary is less helpful. Acknowledging the unfairness of the client's situation does not address the client's needs at this time.

CN: Psychosocial integrity; CL: Synthesize

115. 3. The client with anxiety may be able to learn to recognize when she is feeling anxious, understand the reasons for her anxiety, and be able to describe situations that preceded her feelings of anxiety. However, she is likely to continue to experience symptoms unless she has also learned to use adaptive and palliative methods to reduce anxiety.

CN: Psychosocial integrity; CL: Synthesize

116. 4. Saying, “The accident just happened and could not have been predicted,” provides the client with an objective perception of the event instead of the client's perceived role. This type of statement reflects active listening and helps to reduce feelings of blame and guilt. Saying, “Don't keep torturing yourself,” or “Stop blaming yourself,” is inappropriate because it tells the client what to do, subsequently delaying the therapeutic process. The statement, “Let's talk about something that is a bit more pleasant,” ignores the client's feelings and changes the subject. The client needs to verbalize feelings and decrease feelings of isolation.

CN: Psychosocial integrity; CL: Synthesize

117. 1. The nurse states, “You did what you had to do at that time,” to help the client evaluate past behavior in the context of the trauma. Clients commonly feel guilty about past behaviors when viewing them in the context of current values. The other statements are inappropriate because they do not help the client to evaluate past behavior in the context of the trauma.

CN: Psychosocial integrity; CL: Synthesize

118. 2. Writing in a journal can help the client safely express feelings, particularly anger, when the client cannot verbalize them. Safely externalizing anger by writing in a journal helps the client to maintain control over her feelings.

CN: Psychosocial integrity; CL: Synthesize

119. 3. The nurse should facilitate progressive review of the accident and its consequences to help the client integrate feelings and memories and to begin the grieving process. Helping the client to evaluate her sister's behavior, telling the client to avoid details of the accident, or postponing the discussion of the accident until the client brings it up is not therapeutic and does not facilitate the development of trust in the nurse. Such actions do not facilitate review of the accident, which is necessary to help the client integrate feelings and memories and begin the grieving process.

CN: Management of care; CL: Create

120.

3. Remove any weapons and dangerous items he has in his possession.

1. Remind him that any feelings and problems he is having are typical in his current situation.

4. Acknowledge any injustices/unfairness related to his experiences and offer empathy and support.

2. Ask him to talk about his upsetting experiences.

Safety is the first priority in clients experiencing Acute Stress Disorder (ASD). ASD symptoms are typical reactions to an abnormal situation that are not being handled effectively. When the client believes he is "normal," being accepted, understood, and supported, then he will be able to discuss his thoughts and feelings related to the traumas of the war.

CN: Safety and infection control; CL: Synthesize

121. 4. Survivors of trauma/torture have a lot of difficulty with trust and do not readily talk about the horrible events. Therefore, empathy and a willingness to listen without pressuring the client are crucial. Option 1 may or may not be possible and does not convey the empathy. It is sometimes difficult to believe what satanic cults can do to children. Option 2 diverts attention from the client to the mother. Option 3 shows more interest in the cult than the client.

CN: Psychosocial integrity; CL: Synthesize

122.

3. Ask the client to sign a No Harm Contract related to suicide and self-mutilation.

1. Ask the client about the step-dad possibly abusing younger children in the family.

2. Ask the client to be specific about what he means by “screwed up.”

4. Ask the client to talk about appropriate ways to express anger toward his mother.

The nurse should first assure the client's safety after the client's self-mutilation. Another safety issue is whether the stepdad possibly may be abusing younger children; if so, a police report may need to be filed. Then, it is important to know what the client means exactly by “screwed up” to identify other emotions and behaviors that need attention. It is very common for survivors of childhood sexual abuse to have intense anger at those who did not stop or prevent the abuse, and once the other steps have been taken, the nurse can begin to help the client manage his anger.

 CN: Reduction of risk potential; CL: Synthesize

123. 1, 2, 4, 6. Relaxation techniques and listening to calming music decrease anxiety and promote sleep. Seroquel is often effective in decreasing nightmare and flashbacks and has a beneficial side effect of drowsiness. Leaving her door slightly open will decrease the noise of making 15-minute checks at night. Staying in the dayroom in a recliner with all the noise and lights is not likely to help. Processing memories an hour or two before bedtime doesn't allow enough time to calm down before sleep.

 CN: Psychosocial integrity; CL: Synthesize

124. 4. The nurse judges the client's request for an interruption in treatment as a necessary break in treatment. A “time-out” is common and necessary to enable the client to focus on pressing problems and solutions. It is not necessarily a method of avoidance, a detriment to progress, or the end of treatment. A problem like housing can be very stressful and require all of the client's energy and attention, with none left for the emotional stress of treatment.

 CN: Management of care; CL: Analyze

125. 1. Combining a benzodiazepine with an antacid impairs the absorption rate of the benzodiazepine. Acetaminophen, vitamins, and aspirin are safe to take with a benzodiazepine because no major drug interactions occur.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

126. 2. Valium, like any benzodiazepine, cannot be stopped abruptly. The client must be slowly tapered off of the medication to decrease withdrawal

symptoms, which would be similar to withdrawal from alcohol. Alcohol in combination with a benzodiazepine produces an increased central nervous system depressant effect and therefore should be avoided. Valium can cause drowsiness, and the client should be warned about driving until tolerance develops. Valium has muscle relaxant properties and will help tight, tense muscles feel better.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

127. 3. The nurse should suggest behavior therapy, which is most successful for clients with phobias. Systematic desensitization, flooding, exposure, and self-exposure treatments are most therapeutic for clients with phobias. Self-exposure treatment is being increasingly used to avoid frequent therapy sessions. Insight therapy, exploration of the dynamics of the client's personality, is not helpful because the process of anxiety underlies the disorder. Group therapy or psychoanalysis, which deals with repressed, intrapsychic conflicts, is not helpful for the client with phobias because it does not help to manage the underlying anxiety or disorder.

 CN: Psychosocial integrity; CL: Apply

128. 4. Saying, “It's a sign of progress to eat in the dining area with me,” conveys positive reinforcement and gives the client hope and confidence, thus reinforcing the adaptive behavior. Stating, “It wasn't so hard, now was it,” decreases the client's self-worth and minimizes his accomplishment. Stating, “At supper, I hope to see you eat with a group of people,” will overwhelm the client and increase anxiety. Stating, “You must have been hungry today,” ignores the client's positive behavior and shows the nurse's lack of understanding of the dynamics of the disorder.

 CN: Psychosocial integrity; CL: Synthesize

129. 4. The nurse should walk with the client to activate adaptive coping for the client experiencing high anxiety and decreased motivation and energy. Stating, “I know you can do it,” “Try holding on to the wall,” or “You can miss group this one time,” maintains the client's avoidance, thus reinforcing the client's behavior, and does not help the client begin to cope with the problem.

 CN: Psychosocial integrity; CL: Synthesize

130. 2. The effectiveness of St. John's wort with depression is unconfirmed. The critical issue is that the combination of St. John's wort and Zoloft (a SSRI antidepressant) can produce serotonin syndrome, which can be fatal. The client should not take the St. John's wort while taking Zoloft.

CN: Pharmacological and parenteral therapies; CL: Apply

131. 1. When the client says he thinks he is “going crazy,” it is best for the nurse to ask him what “crazy” means to him. The nurse must have a clear idea of what the client means by his words and actions. Using an open-ended question facilitates client description to help the nurse assess his meaning. The other statements minimize and dismiss the client's concern and do not give him the opportunity to openly discuss his feelings, possibly leading to increased anxiety.

CN: Psychosocial integrity; CL: Synthesize

132. 1. A client who is exhibiting compulsive behavior is attempting to control his anxiety. The compulsive behavior is performed to relieve discomfort and to bind or neutralize anxiety. The client must perform the ritual to avoid an extreme increase in tension or anxiety even though the client is aware that the actions are absurd. The repetitive behavior is not an attempt to control thoughts; the obsession or thinking component cannot be controlled. It is not an attention-seeking mechanism or an attempt to express hostility.

CN: Psychosocial integrity; CL: Analyze

133. 2. The nurse should wake the client an hour earlier to perform his ritual so that he can be on time for breakfast with the other clients. The nurse provides the client with time needed to perform rituals because the client needs to keep his anxiety in check. The nurse should never take away a ritual, because panic will ensue. The nurse should work with the client later to slowly set limits on the frequency of the action.

CN: Pharmacological and parenteral therapies; CL: Synthesize

134. 3. The nurse conveys empathy and awareness of the client's need to reduce anxiety by showing acceptance and understanding to the client, thereby promoting trust. Ignoring the behavior, questioning the client about her avoidance of others, or telling other clients to follow her when she moves are not therapeutic or appropriate.

CN: Psychosocial integrity; CL: Synthesize

135. 1, 3, 4, 6. Managing suicidal thought, urges to self-mutilate, and the intense anger are critical safety issues. Then the focus can switch to communication methods for each alter and the integration issues. Process groups can be overwhelming when too much is revealed or when child alters are unable to understand the group content. There are no known medicines to stop the process of dissociating.

CN: Management of care; CL: Create

136. 1, 2, 3, 6. A client experiencing a dissociate fugue needs to feel safe and supported as well as evaluated medically and neurologically. Then it is appropriate to discuss what she can remember about the trip to the bank and her feelings about all that has happened to her since then. It is not appropriate to seclude her from others or to apply pressure to get details about the crime at this time. The police and the bank will ask these questions during their investigations.

 CN: Psychosocial integrity; CL: Create

137. 3. The No Harm Contract with any destructive alters is essential along with the reminder that the alters share the same body. Later, the alter's attitudes about the client can be explored in more depth. When alter personalities emerge, their behaviors are not predictable. Restraints could not be placed on the client soon enough. There are no behaviors to justify restraints at this point. Creating a stress-free environment is not possible.

 CN: Safety and infection control; CL: Synthesize

The Client with a Somatoform Disorder

138. 4. The nurse sets limits by informing the client in a matter-of-fact manner that the nurse cannot give her additional pain medication at this time. Then the nurse invites the client to participate in a card game to decrease rumination about pain by directing the client's attention to an activity. By telling the client the nurse will call the primary health care provider as requested, the nurse is manipulated to do what the client demands. Suggesting that the client lie down because she has to wait for the next dosage or telling the client that the primary health care provider will be in later ignores the client and her needs and is not helpful in decreasing rumination about her pain.

 CN: Psychosocial integrity; CL: Synthesize

139. 3. The nurse instructs the UAP to invite the client to lunch and accompany him to the dining room to decrease manipulation, secondary gain, dependency, and reinforcement of negative behavior while maintaining the client's self-worth. Taking the client a lunch tray and allowing him to eat in his room reinforces negative behaviors and secondary gain. Telling the client he'll need to wait until supper to eat if he misses lunch or informing the client that he has 10 minutes to get to the dining room challenges the client and may increase feelings of anger and the need for physical complaints.

 CN: Management of care; CL: Synthesize

140. 2. Pushing insight or awareness into conflicts or problems increases

anxiety and the need for physical symptoms to handle or take care of the anxiety. Awareness or insight must be developed slowly as the client's need for symptoms diminishes. Saying “Ignore the client's behavior and treat her with respect” is not helpful to the staff member or the client. This statement fails to educate the staff member about the client's disorder and simply dismisses the needs of both. It is not true that pushing awareness will be helpful and further the client's recovery; this is the opposite of what is needed. Meeting with the client to confront her behavior is not therapeutic and will greatly increase the client's anxiety and the need for the conversion symptoms.

 CN: Management of care; CL: Synthesize

141. 2. The nurse helps the client to focus on his feelings about his impending divorce to decrease the client's anxiety and decrease his focus on physical ailments. The client with a somatoform disorder typically has problems with identifying, describing, and dealing with feelings. Internalizing feelings leads to increased anxiety and the need for protective mechanisms. Asking the client to describe his problem with nausea, allowing the client to talk about the many primary health care providers he has seen and the medications he has taken, and informing the client about a different medication for nausea are counterproductive toward recovery because they reinforce the focus on the symptoms.

 CN: Psychosocial integrity; CL: Synthesize

142. 4. The nurse should redirect the interaction back to fishing or another focus whenever the client begins to ruminate about physical symptoms or impairment. Doing so helps the client talk about topics that are more therapeutic and beneficial to recovery. Allowing the client to talk about his pain or asking if he needs additional pain medication is not therapeutic because it reinforces the client's need for the symptom. Getting up and leaving the client is not appropriate unless the nurse has set limits previously by saying, “I will get up and leave if you continue to talk about your pain.”

 CN: Psychosocial integrity; CL: Synthesize

143. 1. The client who states, “I understand my pain will feel worse when I'm worried about my divorce” recognizes the connection between his pain and the divorce and indicates developing insight into his problem. The nurse should then be able to assist the client with developing adaptive coping strategies. The other statements indicate a lack of insight into his disorder and lack of progress toward recovery. The client is still searching for the “right” diagnosis, medication, and doctor.

CN: Psychosocial integrity; CL: Evaluate

Managing Care Quality and Safety

144.

3. Page the ED primary health care provider and prepare to give diazepam (Valium) intravenously.

1. Monitor the client's safety and place seizure pads on the cart rails.

2. Record the time, duration and nature of the seizures.

4. Ask the friend about the client's medical history and current medications.

The nurse should first obtain a prescription for and administer diazepam (Valium) to stop the status epilepticus. The nurse should next prevent injury by using seizure pads. Recording the time, duration, and nature of the seizures will be important for ongoing treatment. Finally, the nurse can attempt to obtain information about medication use and abuse history from the friend until the client is able to do so for himself.

CN: Safety and infection control; CL: Synthesize

145.

3. Get close to Annie and protect her from injury until she calms down.

1. Ask the other clients to leave the room and meet with another nurse.

4. Ask Annie about what happened to her during the group.

2. Ask Becky to talk about what happened to her during the group therapy session.

The safety of the client is the top priority. Then the nurse can ask the other

clients to leave and meet with another nurse to discuss their feelings about what happened in the group session since this event will likely be very disturbing to the other group members. When Annie, the alter personality, is calmer, the nurse can discuss what triggered her emergence and what she experienced. Then when Becky reemerges, it is appropriate to discuss what she remembers and her feeling about the event.

CN: Safety and infection control; CL: Synthesize

146. 1. Having a qualified sitter stay with the client provides for reassurance and safety. Being next to the nursing desk will increase stimuli and confusion. Being alone will increase the client's fears and anxiety. It is inappropriate to ask the boyfriend to provide client supervision for the nurse.

CN: Safety and infection control; CL: Synthesize

147.

5. Remind the client that she is in the hospital and the nurse is with her.
2. Implement constant observation.
4. Administer haloperidol (Haldol) and lorazepam (Ativan) IM as prescribed
3. Monitor vital signs every 15 minutes.
1. Obtain a prescription to place the client in restraints, if needed.
6. Chart the client's response to the interventions.

After orienting the client to time and place, the nurse should assure constant observation of the client to prevent the client from getting hurt. The administration of the Haldol and Ativan are needed to quickly decrease the symptoms of delirium tremens (DTs) and lower the vital signs. Monitoring vital signs assesses the client's stability and need for additional medications. The nurse can ask another staff to contact the health care provider to request a prescription for restraints in case the client becomes violent toward self or others. After the DT symptoms subside, the Haldol would be stopped due to the

decrease in the seizure threshold. Other detoxification protocols would then begin. Last, chart the client's response.

CN: Safety and infection control; CL: Synthesize

148. 2. The statement, “The client is a weak individual and could stop if he desires,” is false and indicates a lack of understanding regarding alcohol dependency. Criteria for substance dependency includes the inability to stop using even when wanting to do so. The client cannot stop or control the amount used when dependent on a substance. Alcohol dependency affects individuals from every culture and socioeconomic background and has nothing to do with being a “weak” individual. The devastating effects of alcohol dependency are felt by every member of the family and not just the individual with the alcohol problem. Family members need education about the physical, physiologic, and psychological effects of alcohol and referrals to self-help groups for support. They have felt and lived with the devastating effects of the disease. A simple and commonly held view of alcoholism is that alcohol is a problem when it interferes with life or disrupts family, work, or social relationships.

CN: Management of care; CL: Evaluate

149. 1. Some behavior that is legally allowed might not be considered ethically appropriate. Legal and ethical standards are often linked, such as in the commandment “Thou shalt not kill.” Ethical standards are never irrelevant, though a client's safety or the safety of others may pose an ethical dilemma for health care personnel. Searching a client's room when they are not there is a violation of their privacy. Room searches can be done with a primary health care provider's prescription and generally are done with the client present.

CN: Management of care; CL: Apply

150.

3. Nurse 1's genuine concern about Nurse 2, her pain, and behaviors.

1. The type, dose, and frequency of use of the pain medication by Nurse 2.

4. Nurse 1's suspicion that Nurse 2 may be using a client's pain medication for herself.

2. The importance of the two of them going to their supervisor about Nurse

2's recent problems.

Unless Nurse 2 believes that Nurse 1 cares about her and her needs, she is likely to deny having any problem. Knowing details about Nurse 2's pain medications, helps Nurse 1 assess the severity of Nurse 2's medication abuse. Then it is appropriate to address the possibility of Nurse 2 using a client's pain medication. Going to their supervisor is the next step in helping Nurse 2 get treatment assistance.

CN: Management of care; CL: Analyze

151.

1. Contact the security department.

2. Obtain an EKG.

4. Obtain a prescription for a urine sample.

3. Initiate a referral to obtain drug rehabilitation counseling.

The nurse should first provide for safety of the client and the staff by requesting assistance from the security department. Next, the nurse should obtain an EKG because the client reports having chest pain. The nurse should then obtain a prescription for a urine sample to identify if the client has been using illegal drugs. When the client is stabilized, the nurse can develop a care plan that includes treatment goals to support the respiratory and cardiovascular functions and enhance clearance of the agent, and initiate a referral for treatment where access to the drug is eliminated and drug rehabilitation is provided as part of therapeutic management of clients with substance abuse and/or a drug overdose.

CN: Reduction of risk potential; CL: Analyze

TEST 4: Stress, Crisis, Anger, and Violence

The Client Managing Stress

1. The nurse cares for a middle-aged client with a below-the-knee amputation. Which statement indicates the need for further assessment of the client's body image?

☐ **1.** “When I get my prosthesis, I want to learn to walk so I can participate in walkathons.”

☐ **2.** “I hope to get skilled enough at using my prosthesis to help others like me adjust.”

☐ **3.** “Whenever I start to feel sorry for myself, I remember that my buddy died in that accident.”

“I hope I can handle having a prosthesis, but I'm really wondering what my wife will think.”

2. A client demonstrates moderate anxiety regarding a pending medical procedure. The nurse should do which of the following to minimize the client's anxiety about the procedure?

☐ **1.** Assuring the client that pain is not associated with the procedure.

☐ **2.** Providing a brief explanation and then doing the procedure quickly.

☐ **3.** Giving a demonstration of what is to be done.

☐ **4.** Indicating to the client that it is normal to feel anxious and fearful before such a procedure.

3. A 75-year-old client is newly diagnosed with diabetes. The nurse is instructing him about blood glucose testing. After the session, the client states, “I can't be expected to remember all this stuff.” The nurse should recognize this response as most likely related to which of the following?

☐ **1.** Moderate to severe anxiety.

☐ **2.** Disinterest in the illness.

☐ **3.** Early-onset dementia.

☐ **4.** Normal reaction to learning a new skill.

4. A client in a general hospital is to undergo surgery in 2 days. He is experiencing moderate anxiety about the procedure and its outcome. To help the client reduce his anxiety, the nurse should:

☐ **1.** Tell the client to distract himself with games and television.

☐ **2.** Reassure the client that he will come through surgery without incident.

☐ **3.** Explain the surgical procedure to the client and what happens before and after surgery.

☐ **4.** Ask the surgeon to refer the client to a psychiatrist who can work with the client to diminish his anxiety.

5. Anxiety occurs in degrees, from a level that stimulates productive problem solving to a level that is severely debilitating. At a mild, productive level of anxiety, the nurse should expect to see which of the following as a cognitive characteristic of mild anxiety?

☐ **1.** Slight muscle tension.
☐ **2.** Occasional irritability.
☐ **3.** Accurate perceptions.
☐ **4.** Loss of contact with reality.

6. As a client's level of anxiety increases to a debilitating degree, the nurse should expect which of the following as a psychomotor behavior indicating a panic level of anxiety?

☐ **1.** Suicide attempts or violence.
☐ **2.** Desperation and rage.
☐ **3.** Disorganized reasoning.
☐ **4.** Loss of contact with reality.

7. Nursing interventions with an anxious client change as the anxiety level increases. At a low level of anxiety, the primary focus of interventions is on which of the following?

☐ **1.** Taking control of the situation for the client.
☐ **2.** Learning and problem solving.
☐ **3.** Reducing stimuli and pressure.
☐ **4.** Using tension reduction activities.

8. When coping becomes dysfunctional enough to require the client to be admitted to the hospital, the nurse should assess the client for the ability to demonstrate which of the following?

☐ **1.** Objective and rational problem solving.
☐ **2.** Tension reduction activities and then problem solving.
☐ **3.** Anger management strategies with no problem solving.
☐ **4.** Minimal functioning with new problems developing.

9. In addition to teaching assertiveness and problem-solving skills when helping the client cope effectively with stress and anxiety, the nurse should also address the client's ability to:

☐ **1.** Suppress anger.
☐ **2.** Balance a checkbook.
☐ **3.** Follow step-by-step directions.
☐ **4.** Use conflict resolution skills.

10. Which client statement indicates that the client has coped effectively with a relationship problem?

☐ **1.** “My wife will be happy to know that I can spend less time at work now.”
☐ **2.** “My wife and I are talking about our likes and dislikes in activities.”
☐ **3.** “I can understand how my wife and I see things differently.”
“We are really listening to each other about our different views on issues.”

11. In an ongoing assessment, the nurse should identify the client's thoughts and feelings about a situation in addition to which of the following?

☐ **1.** Whether the client's behavior is appropriate in the context of the current situation.
☐ **2.** Whether the client is motivated to decrease dysfunctional behaviors.
☐ **3.** Which of the client's problems have the highest priority.
☐ **4.** Which of the client's behaviors necessitates a no-harm contract.

12. When developing appropriate short-term goals with clients who are inpatients, which of the following is **most** realistic?

☐ **1.** The client will demonstrate a positive self-image.
☐ **2.** The client will describe plans for how to get back into school.
☐ **3.** The client will write a list of strengths and needs.
☐ **4.** The client will practice assertiveness skills in confronting his mother.

13. A nurse is counseling a client with cancer who is experiencing anxiety. Which goal will provide the best long-term client outcome?

☐ **1.** Keep follow-up appointments with psychiatrists.
☐ **2.** Understand medication effects and adverse effects.
☐ **3.** Take medication as prescribed.
☐ **4.** Solve problems without help from others.

14. When integrating the concepts underlying the cognitive-behavioral model into a client's plan of care, the nurse should focus on which of the following areas?

☐ **1.** Substitution of rational beliefs for self-defeating thinking and behaving.
☐ **2.** Insight into unconscious conflicts and processes.
☐ **3.** Analysis of fears and barriers to growth.
☐ **4.** Reduction of bodily tensions and stress management.

15. Which of the following client statements indicates that the client has gained insight into his use of the defense mechanism of displacement?

☐ **1.** “I can't think about the weekend right now. I've got to study for the exam.”
☐ **2.** “I know I'm not good in sports, but I feel good about my grades.”
“Now when I'm mad at my wife, I talk to her instead of taking it out on the

kids.”

☐ **4.** “For years I couldn't remember being molested; now I know I have to face it.”

16. In which of the following situations can a client's confidentiality be breached legally?

☐ **1.** To answer a request from a client's spouse about the client's medication.
☐ **2.** In a student nurse's clinical paper about a client.
☐ **3.** When a client near discharge is threatening to harm an ex-partner.
☐ **4.** When a client's employer requests the client's diagnosis to initiate medical claims.

17. A client is admitted after the police found he had been sleeping in his car for three nights. The client says, “My wife kicked me out and is divorcing me. It wasn't my fault I was fired from work. My wife and boss are plotting against me because I am smarter than they are.” He then pounds the table and says, “I'm not staying here, and you can't stop me.” Which of the following should be included in the client's plan of care? Select all that apply.

☐ **1.** Collateral information from his wife and boss.
☐ **2.** Anxiety and anger management.
☐ **3.** Appropriate housing.
☐ **4.** Divorce counseling.
☐ **5.** Assault and escape precautions.
☐ **6.** Suspiciousness and grandiosity issues.

18. Which of the following is a crucial goal of therapeutic communication when helping the client deal with personal issues and painful feelings?

☐ **1.** Communicating empathy through gentle touch.
☐ **2.** Conveying client respect and acceptance even if not all of the client's behaviors are tolerated.
☐ **3.** Mutual sharing of information, spontaneity, emotions, and intimacy.
☐ **4.** Guaranteeing total confidentiality and anonymity for the client.

19. An 18-year-old pregnant college student presented at the prenatal clinic for an initial visit at 14 weeks' gestation. The client's history revealed that when she was 12, she and her mother survived a plane crash that killed her father and sister. Since that time, she has taken Prozac (fluoxetine) 20 mg orally daily for posttraumatic stress disorder (PTSD) and depression. Her medication was recently increased to 40 mg daily because of reports of increased stress and suicide ideation. Which of the following side effects of Prozac would the nurse judge to be the greatest risk for the young woman and her developing fetus at this stage in her pregnancy?

☐ **1.** Insomnia.
☐ **2.** Nausea/anorexia.
☐ **3.** Headache.
☐ **4.** Decreased libido.

20. Which of the following questions or statements should the nurse use to encourage client evaluation of his or her own behavior?
☐ **1.** “I can hear that it's still hard for you to talk about this.”
☐ **2.** “So what does this all mean to you now?”
“What did you do differently with your coworker this time?”
☐ **4.** “What will it take to carry out your new plans?”

21. With shorter lengths of stay becoming the norm, which statement is true of the stages of the nurse-client relationship?
☐ **1.** Different phases of the relationship involve emphasizing different processes and goals related to client needs.
☐ **2.** Building trust is the most that can be accomplished during the relationship.
☐ **3.** What can be achieved during the relationship is problem identification and referrals.
☐ **4.** Teaching new skills becomes the most important aspect of the relationship phases.

22. Even when the client understands problems and is motivated to change, the client may have fears about failing. Which of the following interventions is most likely to facilitate change?
☐ **1.** Reality testing about the need for change.
☐ **2.** Asking the client about fears that need to be overcome.
☐ **3.** Teaching new communication skills.
☐ **4.** Practicing new behaviors with the nurse.

The Client Coping with Physical Illness

23. A mastectomy is recommended for a 68-year-old client diagnosed with breast cancer a week ago. When approached about giving consent for the mastectomy, the client says, “What is the use in trying to get rid of the cancer? It will just come back! I can't handle another thing—having diabetes is enough. Besides, I'm getting old. It would be different if I were younger and had more energy.” What should the nurse do?

☐ **1.** Accept the client's decision since it is her right to choose to obtain treatment or not.
☐ **2.** Give the client information about the 5- and 10-year survival rates for breast cancer clients who underwent mastectomies.
☐ **3.** Call the chaplain to speak with the client about her hopeless attitude about the future.
☐ **4.** Explore with the client her feelings about her health problems and proposed surgery.

24. An 18-year-old client is recently diagnosed with leukemia. What is the **most** appropriate short-term goal for the nurse and client to establish?

☐ **1.** Accepting the client's death as imminent.
☐ **2.** Expressing the client's angry feelings to the nurse.
☐ **3.** Decreasing interaction with peers to conserve energy.
☐ **4.** Gaining an intellectual understanding of the illness.

25. The nurse has been asked to develop a medication education program for clients with chronic mental illness in the rehabilitation program. When developing the course outline, which of the following topics is **most** important to include?

☐ **1.** A categorization of many psychotropic drugs.
☐ **2.** Interventions for common side effects of psychotropic drugs.
☐ **3.** The role of medication in the treatment of acute illness.
☐ **4.** Effects of combining common street drugs with psychotropic medication.

26. The primary health care provider recommends that a client have a partial bowel resection and an ileostomy. Later, the client says to the nurse, “That doctor of mine surely likes to play big. I'll bet the more he can cut, the better he likes it.” Which of the following replies by the nurse is **most** therapeutic?

☐ **1.** “I can tell you more about the surgery if you like.”
“What do you mean by that statement?”

☐ **3.** “Aren't you being a bit hard on him? He's trying to help you.”
☐ **4.** “Does that remark have something to do with the operation he wants you to have?”

27. A client becomes increasingly morose and irritable after being told that she has cancer. She is rude to visitors and pushes nurses away when they attempt to give her medications and treatments. Which of the following should the nurse do when the client has a hostile outburst?
☐ **1.** Offer the client positive reinforcement each time she cooperates.
☐ **2.** Encourage the client to discuss her immediate concerns and feelings.
☐ **3.** Continue with the assigned tasks and duties as though nothing has happened.
☐ **4.** Encourage the client to direct her anger at staff members instead of her visitors.

28. Arrangements are made for a member of the colostomy club to meet with a client before bowel surgery. Which of the following is accomplished by having a representative from the club visit the client preoperatively?
☐ **1.** Letting the client know that he has resources in the community to help him.
☐ **2.** Providing support for the primary health care provider's plan of therapy for the client.
☐ **3.** Providing the client with support and realistic information on the colostomy.
☐ **4.** Convincing the client that he will not be disfigured and can lead a full life.

29. The client hospitalized for diagnosis and treatment of atrial fibrillation states to the nurse, “Please hand me the telephone. I need to check on my stocks and bonds.” Which of the following responses by the nurse is **most** therapeutic?
☐ **1.** “You will get more upset if you make that call.”
“You have atrial fibrillations. Let's talk about what that means.”
☐ **3.** “You really don't care about the fact that you're sick, do you?”
☐ **4.** “Do you realize you have a life-threatening condition?”

30. The nurse should determine that a client lacks understanding of her acute cardiac illness and the ability to make changes in her lifestyle by which of the following statements?
“I already have my airline ticket, so I won't miss my meeting tomorrow.”
☐ **2.** “These relaxation tapes sound okay; I'll see if they help me.”
☐ **3.** “No more working 10 hours a day for me unless it's an emergency.”
☐ **4.** “I talked with my husband yesterday about working on a new budget together.”

31. A 45-year-old client has been rehospitalized with a severe exacerbation of lupus that affects her central nervous system. Her husband approaches the nurse. He says, “My wife is scaring me. She says she does not want to live with this illness anymore. Our kids are grown, and she feels useless as a mother and a wife.” Which of the following statements are the most appropriate responses to the husband? Select all that apply.

“I will have a talk with your wife to see if she is suicidal.”

☐ **2.** “You need to be strong and optimistic when you are with her.”

“I'm glad you shared this with me. I can imagine that this is scary for you.”

☐ **4.** “I'm sure she will feel differently when we get this episode under control.”

“We can talk about what you can say to her that may help.”

32. The client with kidney stones refuses to eat lunch and rudely tells the nurse to get out of his room. Which of the following responses by the nurse is appropriate?

☐ **1.** “I'll leave, but you need to eat.”

☐ **2.** “I'll get you something for your pain.”

☐ **3.** “Your anger doesn't bother me. I'll be back later.”

“You sound angry. What is upsetting you?”

33. A client diagnosed with ulcerative colitis also experiences obsessive compulsive anxiety disorder (OCD). In helping the client understand her illness, the nurse should respond with which of the following statements?

☐ **1.** “Your ulcerative colitis has made you perfectionistic, and it has caused your OCD.”

☐ **2.** “There is no relationship at all between your colitis and your OCD. They are separate disorders.”

☐ **3.** “The perfectionism and anxiety related to your obsessions and compulsions have led to your colitis.”

“It is possible that your desire to have everything be perfect has caused stress that may have worsened your colitis, but there's no proof that either disorder caused the other.”

34. A client receiving dialysis directs profanities at the nurse and then abruptly hangs his head and pleads, “Please forgive me. Something just came over me. Why do I say those things?” The nurse interprets this as which of the following?

☐ **1.** Neologism.

☐ **2.** Confabulation.

☐ **3.** Flight of ideas.

☐ **4.** Emotional lability.

35. On an oncology unit, the nurse hears noises coming from a client's room. The client is found throwing objects at the walls and has just picked up the phone. She is screaming, “How can God do this to me? It is the third type of cancer I've had. I've gone through all the treatment for nothing.” In what order of priority from first to last should the nurse make the following interventions?

1. “Tell me what you are feeling right now.”
2. “Please put the telephone down so we can talk.”
3. “I can hear how upset you are about the cancer.”
4. “I wonder if you would like to talk to a clergyman.”

36. A client who has had AIDS for years is being treated for a serious episode of pneumonia. A psychiatric nurse consult was arranged after the client stated that he was tired of being in and out of the hospital. “I'm not coming in here any more. I have other options.” The nurse would evaluate the psychiatric nurse consult as helpful if the client makes which of the following statements?

☐ **1.** “Nobody wants me to commit suicide.”

☐ **2.** “If I talk about suicide, I'll be transferred to the psychiatric unit.”

“I realize that I really do have more time to enjoy my family and friends.”

☐ **4.** “I'd probably screw up suicide anyway.”

The Client in Crisis

37. The nurse's overall goal in planning to assist the client responding to a loss is to:

☐ **1.** Make sure the client progresses through all of the stages of the grief process.
☐ **2.** Encourage the client to work to resolve lingering family conflicts.
☐ **3.** Assist the client to engage in the work associated with the normal grieving process.
☐ **4.** Allow the client to express anger.

38. The nurse working at the site of a severe flood sees a woman, standing in knee-deep water, staring at an empty lot. The woman states, “I keep thinking that this is a nightmare and that I'll wake up and see that my house is still there.” Which of the following crisis intervention strategies are most needed at this time? Select all that apply.

☐ **1.** Ask the client about any physical injuries she may have.
☐ **2.** Determine if any of her family are injured or missing.
☐ **3.** Allow the client to talk about her fears, anger, and other feelings.
☐ **4.** Tell her that groups are being formed at the shelter for flood survivors.
☐ **5.** Refer her to the shelter for dry clothes and food.
☐ **6.** Assess her for risk of suicide and other signs of decompensation.

39. The nurse is assessing a client who has just experienced a crisis. The nurse should first assess this client for which of the following behaviors?

☐ **1.** Effective problem solving.
☐ **2.** Level of anxiety.
☐ **3.** Attention span.
☐ **4.** Help-seeking.

40. An anxious young adult is brought to the interviewing room of a crisis shelter, sobbing and saying that she thinks she is pregnant but does not know what to do. Which of the following nursing interventions is **most** appropriate at this time?

☐ **1.** Ask the client about the type of things that she had thought of doing.
☐ **2.** Give the client some ideas about what to expect to happen next.
☐ **3.** Recommend a pregnancy test after acknowledging the client's distress.
☐ **4.** Question the client about her feelings and possible parental reactions.

41. A potentially pregnant 16-year-old client says that she has been "hooking up" with a boy she considers to be her boyfriend. Which of the following responses should the nurse make **first**?

☐ **1.** "You mean you have had sexual intercourse?"

"Describe what you mean by hooking up."

☐ **3.** "I think we need to talk about what's involved in sexual intercourse."

☐ **4.** "All you have been doing with your boyfriend is hooking up?"

42. A 40-year-old client who is quite anxious says that she would "rather die than be pregnant." Which of the following responses by the nurse is **most** helpful?

☐ **1.** "Try not to worry until after the pregnancy test."

☐ **2.** "You know, pregnancy is a normal event."

☐ **3.** "You're only 40 years old and not too old to have a baby."

"I see you're upset. Take some deep breaths to relax a little."

43. On a crisis shelter hotline, the nurse talks to two 11-year-old boys who think a friend sniffs glue. They say his breath sometimes smells like glue and he acts drunk. They say they are afraid to tell their parents about the friend. When formulating a reply, the nurse should consider which of the following?

☐ **1.** The boys probably fear punishment.

☐ **2.** Sniffing glue is illegal.

☐ **3.** The boys' observations could be wrong.

☐ **4.** Glue sniffing is a minor form of substance abuse.

44. While teaching a group of volunteers for a crisis hotline, a volunteer asks, "What if I'm not sure why someone is calling?" Which of the following statements by the nurse is **most** helpful?

"Ask the caller to tell you why he or she is calling you today."

☐ **2.** "Tell the caller to make an appointment at the walk-in crisis clinic."

☐ **3.** "Instruct the caller to go to the nearest emergency room."

☐ **4.** "Tell the caller to let you speak to anyone else in the house."

45. After teaching a group of students who are volunteering for a local crisis hotline, the nurse judges that further education about crisis and intervention is needed when a student states which of the following?

☐ **1.** "Callers to a crisis line use this service when they're overwhelmed and exhausted."

☐ **2.** "People use crisis hotlines when they're in the most pain and nothing is working for them."

"Most people in crisis will be calling the line once every day for at least a year."

☐ **4.** "One benefit is that a person will know how to handle stressful situations

better in the future.”

46. A 13-year-old girl, whose family is living in a cult, ran away from the group's compound to her aunt's house. The aunt brought the girl to the emergency department after finding multiple knife cuts in various stages of healing on the girl's body. She is admitted to the unit because of many trauma-related symptoms. The nurse should take which of the following actions? Select all that apply.

☐ **1.** Ask her to describe her experiences in a discussion group with other teens.
☐ **2.** Teach her emotion management skills to help her deal with her “normal reactions to an abnormal situation.”
☐ **3.** Assess her for other possible injuries, pregnancy, and sexually transmitted diseases.
☐ **4.** Teach her ways to control self-destructive behaviors such as suicide attempts, self-mutilation, and rage outbursts.
☐ **5.** Obtain a sample for a urine drug screen and routine urinalysis.
☐ **6.** Help her process her emotions and memories as she is willing to share these.

47. A true crisis state, involving a period of severe disorganization, is difficult to endure emotionally and physically. The nurse recognizes that a client will only be able to tolerate being in crisis for which of the following lengths of time?

☐ **1.** 1 to 2 weeks.
4 to 6 weeks.
☐ **3.** 12 to 14 weeks.
☐ **4.** 24 to 26 weeks.

48. The nurse incorporates the underlying premise of crisis intervention, about providing “the right kind of help at the right time,” to achieve which of the following goals initially?

☐ **1.** Regaining emotional security and equilibrium.
☐ **2.** Resolution of underlying emotional problems.
☐ **3.** Development of insight and personal growth.
☐ **4.** Formulation of more effective support systems.

49. The nurse understands that with the right help at the right time, a client can successfully resolve a crisis and function better than before the crisis, based primarily on which of the following factors?

☐ **1.** Relinquishment of dysfunctional coping.
☐ **2.** Reestablishment of lost support systems.

☐ **3.** Acquisition of new coping skills.
☐ **4.** Gain of crisis prevention knowledge.

50. A client is being discharged after 3 days of hospitalization for a suicide attempt that followed the receipt of a divorce notice. Which of the following, if verbalized by the client, indicates to the nurse that the client is ready for discharge?
☐ **1.** A readiness for discharge.
☐ **2.** Names and phone numbers of two divorce lawyers.
☐ **3.** A list of support persons and community resources.
☐ **4.** Emotional stability.

51. A distraught father is waiting for his son to come out of surgery. He accidentally backed the car into his son, causing multiple fractures and a serious head injury. Which of the following statements by the father should alert the nurse to the need for a psychiatric consultation?
☐ **1.** “My son will be fine, but I may be charged with reckless driving.”
☐ **2.** “His mother is going to kill me when she finds out about this.”
☐ **3.** “I just didn't see him run behind the car.”
“If he dies, there will be nothing for me to do but join him.”

52. A grandson who calls the crisis center expressing concern about his grandmother, who lost her husband a month ago, states, “She has been in bed for a week and is not eating or showering. She told me that she did not want to kill herself, but it's not like her to do nothing for herself. She won't even talk to me when I visit her.” The nurse encourages the grandson to bring his grandmother to the center for evaluation based on which of the following reasons?
☐ **1.** The behaviors may reflect passive suicidal thoughts.
☐ **2.** The behaviors reflect altered role performance.
☐ **3.** Seeing the grandson and grandmother together will be helpful.
☐ **4.** Refusing to talk to the grandson alone indicates a major problem.

53. A 16-year-old client who is being seen by the crisis nurse after making several superficial cuts on her wrist states that all her friends are siding with her ex-boyfriend and won't talk to her anymore. She says she knows that the relationship is over, but “If I can't have him, no one else will.” Which of the following client problems takes the highest priority?
☐ **1.** Situational low self-esteem.
☐ **2.** Risk for other-directed violence.
☐ **3.** Risk for suicide.
☐ **4.** Risk-prone health behavior.

54. A client who comes to the crisis center in a very distressed state tells the

nurse, “I just can't get over being fired last week. I've asked for help. I've talked to friends. I've tried everything to get through this, but nothing is working. Help me!” Which of the following should the nurse use as the initial crisis intervention strategy?

☐ **1.** Referral for counseling.
☐ **2.** Support system assessment.
☐ **3.** Emotion management.
☐ **4.** Unemployment assistance.

55. A major role in crisis intervention is getting a client's significant others involved in helping with the immediate crisis as soon as possible. The nurse should determine that the support persons are prepared to help when they verbalize which of the following?

☐ **1.** The name and phone number of the client's primary health care provider.
☐ **2.** Emergency resources and when to use them.
☐ **3.** The coping strategies they are using.
☐ **4.** Long-term solutions they plan to tell the client to use.

56. During the interview at a crisis center, a newly widowed client reveals the wish “to join my husband in Heaven.” After the nurse asks the client to sign a no harm contract, which of the following statements is appropriate to say next?

“Tell me what feelings you have been experiencing.”
☐ **2.** “Has your husband's estate been settled yet?”
☐ **3.** “What was the cause of your husband's death?”
☐ **4.** “Do you have children who are willing to help you?”

57. A nurse manager of the Crisis Access Center of a psychiatric facility in a major city notices a sudden increase in the number of incoming calls one afternoon. After quickly surveying the call sheets, the nurse finds that most callers are very anxious after military aircrafts flew very low over the city. Which of the following strategies would be **most** appropriate in this situation? Select all that apply.

☐ **1.** Instruct the crisis workers to additionally screen callers about where they were on 9/11/01 and their memories of that event.
☐ **2.** Give the crisis workers a list of symptoms of PTSD and techniques for dealing with these symptoms.
☐ **3.** Ask for an emergency meeting with the managers of the inpatient and outpatient services to formulate a contingency plan for increased services if needed.
☐ **4.** Ask the major media outlets in the city to make a scripted public service announcement about the possible recurrence of symptoms experienced

after the events of 9/11/01.

☐ **5.** Prepare for a scripted interview with the local media about PTSD symptoms and techniques for dealing with these symptoms.

☐ **6.** Ask the Director of Psychiatric Services to call the military to issue an apology for the flyover.

The Client with Problems Expressing Anger

58. A 35-year-old man was experiencing marital discord with his wife of 4 years. When his wife walked out, he became angry, throwing things and breaking dishes. A friend talked him into seeking help at the local mental health center. Which of these questions should the nurse ask **initially** to begin to assess this man's immediate problem?

☐ **1.** "Do you feel in control of yourself at this time?"
☐ **2.** "What did you do to cause your wife to leave?"
☐ **3.** "In hindsight, how might you have managed this situation differently?"
"What led you to come in for help today?"

59. A client is being admitted to a psychiatric outpatient program for counseling for his ongoing emotional symptoms. He is asked to rate the severity of his depression, anxiety, and anger. He states, "I don't have any anger any more. I lost my temper once and nearly hurt my wife. I never got angry again." In which order of priority from first to last should the following principles related to anger be shared with this client?

1. "You can learn effective ways to discuss anger with others and still maintain control."
2. "Anger is a natural emotion occurring in all human relationships."
3. "Holding your anger inside contributes to your depression."
4. "Unexpressed anger has a negative effect on the human body and mind."

60. A female client in an anger management group states, “My doctor tells me I need to get mad more often and not let people tell me what to do. Maybe she thinks I should be more aggressive.” What information should the nurse incorporate in the response to this client?

☐ **1.** Denial of anger and lack of assertiveness can be as serious as aggressiveness.
☐ **2.** Assertive behavior in women is not culturally acceptable.
☐ **3.** The client has most likely misinterpreted what the primary health care provider said.
☐ **4.** The client is trying to gain acceptance by the group.

61. The father of a solider who was killed 2 days ago is admitted after a serious suicide attempt. He is medically stable and has signed a no harm contract. During a talk with the nurse, he says, “Terrorism and war are holding me and the whole world hostage. It's so unfair. I'd rather be dead than live alone in constant fear.” Which of the following nursing interventions are important in the next few days? Select all that apply.

☐ **1.** Discussing effective ways to express justifiable anger.
☐ **2.** Teaching stress management and relaxation techniques.
☐ **3.** Identifying community groups for relatives of military personnel.
☐ **4.** Recommending an antiwar advocacy group.
☐ **5.** Strategizing about ways to increase a personal sense of security.

62. In developing a plan of care for a client who has had previous episodes of angry verbal outbursts, the nurse plans to take an educational approach to the problem. Arrange the following steps the nurse should take from first to last.

1. Assisting the client to recognize the early cues that he is angry.

2. Helping the client identify triggers for his anger.

3. Practicing with the client appropriate ways to express his anger.

4. Identifying alternate ways to express his anger.

63. The treatment team recommends that a client take an assertiveness training class offered in the hospital. Which of the following behaviors indicates that the client is becoming more assertive?

☐ **1.** The client begins to arrive late for unit activities. When asked why he's late, he says, “Because I feel like it!”
☐ **2.** The client asks the nurse to call his employer about his insurance.
☐ **3.** The client asks his roommate to put away his dirty clothes after telling the roommate that this bothers him.
☐ **4.** The client follows the nurse's advice of asking his doctor about being passive-aggressive.

64. Which of the following physiologic responses should the nurse expect as **unlikely** to occur when a client is angry?

☐ **1.** Increased respiratory rate.
☐ **2.** Decreased blood pressure.
☐ **3.** Increased muscle tension.
☐ **4.** Decreased peristalsis.

65. Which of the following responses to anger from others should the nurse expect as common in clients?

☐ **1.** Increased self-esteem.
☐ **2.** Feelings of invulnerability.
☐ **3.** Fear of harm.
☐ **4.** Powerlessness.

66. When planning the care of a client experiencing aggression, the nurse incorporates the principle of “least restrictive alternative,” meaning that less restrictive interventions must be tried before more restrictive measures are employed. Which of the following measures should the nurse consider to be the most restrictive?

☐ **1.** Tension reduction strategies.
☐ **2.** Haloperidol (Haldol) given orally.
☐ **3.** Voluntary seclusion or time-out.
☐ **4.** Haloperidol given intramuscularly.

67. As an angry client becomes more agitated while talking about his problems, the nurse decides to ask for staff assistance in taking control of the

situation when the client demonstrates which of the following behaviors?

☐ **1.** Swearing about his wife's behaviors when discussing marital problems.
☐ **2.** Picking up a pool cue stick and telling the nurse to get out of his way.
☐ **3.** Making a fist and pounding loudly on the table.
☐ **4.** Coming out of his room instead of staying in time-out.

68. The nurse is advising a client with schizophrenia about what to do when she begins to get agitated. The client has been compliant with taking her medications and has worked with clinic staff on dealing with her illness and recognizing when she is becoming agitated. Indicate the order from first to last in which the nurse should suggest the following actions be taken.

1. "Take your oral lorazepam (Ativan)."
2. "Take your oral haloperidol (Haldol)."
3. "Remove yourself to a quiet environment."
4. "Tell trusted people that you are becoming upset."

69. When a client is about to lose control, the extra staff who come to help commonly stay at a distance from the client unless asked to move closer by the nurse who is talking to the client. Which of the following best explains the primary rationale for staying at a distance initially?

☐ **1.** The client is more likely to act out if there is an audience, even additional staff.
☐ **2.** The nurse talking to the client makes the decisions about other staff actions.
☐ **3.** The client is likely to perceive others as being closer than they are and feel threatened.

☐ **4.** When the extra staff is visible, the client is less likely to regain self-control.

70. When preparing to use seclusion as an alternative to restraint for a client who has not yet lost control, the nurse expects to use a room with limited furniture and no access to dangerous articles. What should the nurse also consider as critical for the safety of the client?

☐ **1.** A security window in the door or a room camera.
☐ **2.** Lights that can be dimmed from outside the room.
☐ **3.** A staff member to stay in the room with the client.
☐ **4.** A doctor's prescription for the seclusion before it is initiated.

71. The nurse is required initially to restrain all four of a client's extremities. For which of the following reasons should the nurse anticipate the need to add a full-length restraint blanket?

☐ **1.** The client states that restraints are tight and uncomfortable.
☐ **2.** The staff want extra protection for themselves.
☐ **3.** The client is at risk for injury from fighting the restraints.
☐ **4.** Staff assessment reveals that the client will feel more secure under the blanket.

72. Which of the following is the top priority for the client who is placed in restraints?

☐ **1.** Monitoring the client every 15 minutes.
☐ **2.** Assisting with nutrition and elimination.
☐ **3.** Performing range-of-motion exercise for each limb, one at a time.
☐ **4.** Changing the client's position every 2 hours.

73. According to hospital protocol, after a client is restrained, the staff meet and discuss the restraint situation. In addition to sharing feelings and offering support, what should the nurse identify as the long-term goal?

☐ **1.** Providing feedback to each other on how procedures were handled.
☐ **2.** Comparing the perceptions of the various staff members.
☐ **3.** Deciding when to release the client from restraints.
☐ **4.** Improving the staff's use of restraint procedures.

The Client with Interpersonal Violence

74. A client was brought to the unit and admitted involuntarily. During visiting the next day, the client's brother demands that the client be released immediately. The brother says he might have to hurt staff if the unit door is not opened. In which order of priority from first to last should the following nursing actions be implemented?

1. Call security officers to the unit for the protection of all on the unit.
2. Calmly restate to the client and his brother that the client cannot be released without a primary health care provider's prescription.
3. Quietly ask the other clients and visitors to move to another area of the unit with a staff member.
4. Ask the client's brother to leave the unit quietly when he repeats his demands.

75. Based on a client's history of violence toward others and her inability to cope with anger, which of the following should the nurse use as the **most** important indicator of goal achievement before discharge?

☐ **1.** Acknowledgment of her angry feelings.
☐ **2.** Ability to describe situations that provoke angry feelings.
☐ **3.** Development of a list of how she has handled her anger in the past.
☐ **4.** Verbalization of her feelings in an appropriate manner.

76. A client is admitted to the psychiatric hospital for evaluation after

numerous incidents of threatening others, angry outbursts, and two episodes of hitting a coworker at the grocery store where he works. The client is very anxious and tells the nurse who admits him, “I didn't mean to hit him. He made me so mad that I just couldn't help it. I hope I don't hit anyone here.” To ensure a safe environment, the nurse should **first:**

☐ **1.** Let other clients know that he has a history of hitting others so that they will not provoke him.
☐ **2.** Put him in a private room and limit his time out of the room to when staff can be with him.
☐ **3.** Tell him that hitting others is unacceptable behavior and ask him to tell a staff member when he begins feeling angry.
☐ **4.** Obtain a prescription for a medication to be administered to decrease his anxiety and threatening behavior.

77. A client loses control and throws two chairs toward another client. What should the nurse do next?

☐ **1.** Ask the client to go to the quiet area and talk about the behavior.
☐ **2.** Administer an oral tranquilizer and prepare for a show of determination.
☐ **3.** Process the incident with the client and discuss alternative behaviors.
☐ **4.** Call for assistance to restrain the client and administer an intramuscular tranquilizer.

78. A client with a history of self-mutilation and substance abuse begins talking about memories of torture and ritual abuse that ended 15 years ago. To her knowledge, no others were or are being abused by the parents. To assist the client to recover from such torture and abuse, the nurse should suggest which of the following options ? Select all that apply.

☐ **1.** Dealing with ambivalent feelings toward her parents.
☐ **2.** Planning a confrontation with her parents.
☐ **3.** Determining alternatives to self-destructive behaviors.
☐ **4.** Filing criminal charges against her parents.
☐ **5.** Developing safe ways to deal with her rage and guilt.

79. A woman who was raped in her home was brought to the emergency department by her husband. After being interviewed by the police, the husband talks to the nurse. “I don't know why she didn't keep the doors locked like I told her. I can't believe she has had sex with another man now.” The nurse should respond by saying:

“Let's talk about how you feel. Maybe it would help to talk to other men who have been through this.”
☐ **2.** “Maybe the doors were locked, but the man broke in anyway.”

☐ **3.** “Your wife needs your support right now, not your criticism.”
☐ **4.** “It was not consensual sex. Let's see if your wife was physically injured.”

80. A young man makes an appointment to see the psychiatric nurse at the Employee Assistance Program of a large corporation because his female boss is sending him provocative e-mails and making seductive remarks on his voice mail at home. The nurse informs him about corporate workplace violence guidelines, and he agrees to work with corporate security on the issue. What should the nurse do next?

☐ **1.** Refer the client to his boss's supervisor to file a report.
☐ **2.** Suggest the client contact human resources to request a job transfer.
☐ **3.** Ask the client about his reactions to this situation.
☐ **4.** Report the incident to the client's coworkers who are at risk for similar harassment.

81. A 75-year-old woman was brought to the crisis center by her husband. The husband reports that his wife has been in shock and anxious since her purse was stolen outside of their home. The woman blames herself for being robbed, is worried about her stolen wallet and credit cards, and is afraid to go home. The nurse should do which of the following? Select all that apply.

☐ **1.** Request a prescription for lorazepam (Ativan) to decrease her anxiety.
☐ **2.** Encourage her to talk about the robbery and her feelings.
☐ **3.** Discuss what changes at home would help her feel safe.
☐ **4.** Investigate if she has physical injuries from the robbery.
☐ **5.** Ask her what she thinks she could have done to prevent the robbery.

82. A 35-year-old has been killed as a result of a terrorist attack. What should the nurse advise the friends and relatives of the victim to do during the early stages of the recovery process? Select all that apply.

☐ **1.** Keep in contact with other family and friends.
☐ **2.** Attend memorial or religious services.
☐ **3.** Use relaxation techniques and physical activities.
☐ **4.** Speak out publicly about the impact of the loss.
☐ **5.** Attend community meetings with others who have lost loved ones.

Managing Care Quality and Safety

83. When the client is involuntarily committed to a hospital because he is assessed as being dangerous to himself or others, which of the following rights are lost?

☐ **1.** The right to access healthcare.
☐ **2.** The right to send and receive uncensored mail.
☐ **3.** Freedom from seclusion and restraints.
☐ **4.** The right to leave the hospital against medical advice.

84. The nurse manager on a psychiatric unit is reviewing the outcomes of staff participation in an aggression management program. Evaluation of such a program would be based primarily on which of the following indicators?

☐ **1.** Fewer client injuries during restraint procedures.
☐ **2.** A reduction of complaints by clients' relatives.
☐ **3.** Fewer staff injuries during restraint procedures.
☐ **4.** A reduction in the total number of restraint procedures.

85. A young woman has been stalked and then beaten by an ex-boyfriend. Treatment of her injuries is complete and she is ready for discharge. To ensure the woman's safety and security prior to discharge, the nurse should do which of the following? Select all that apply.

☐ **1.** Determine the current location of the ex-boyfriend.
☐ **2.** Ask if she plans to see the ex-boyfriend again.
☐ **3.** Provide information on resources and a safety plan.
☐ **4.** Ensure that she has a safe place to stay after discharge.
☐ **5.** Obtain consent to send her emergency department records to her family primary health care provider.

86. Jail staff asked for a mental health evaluation of a 21-year-old female arrested on charges of prostitution after she stabbed herself with a fork and woke from nightmares in fits of rage. The evaluation revealed that she was kidnapped and held from ages 8 to 16 by a convicted child pornographer. She said she never contacted her family after her release from captivity. The nurse should do the following in what order of priority from first to last?

1. Initiate suicide precautions and a no harm contract.

2. Ask the client if she wishes to contact her family while hospitalized.

3. Offer empathy and support and be nonjudgmental and honest with her.

4. Encourage safe verbalizations of her emotions, especially anger.

87. The nurse is planning care for a group of clients. Which client should the nurse identify as needing the **most** assistance in accepting being ill?

☐ **1.** An 8-year-old boy who alternately cries for his mother and is angry with the nurse about being hospitalized after a bike accident.

☐ **2.** A 32-year-old woman diagnosed with depression related to lupus erythematosus who discusses her medication's adverse effects with the nurse.

☐ **3.** A 45-year-old man who just suffered a severe myocardial infarction and talks to the nurse about concerns regarding resuming sexual relations with his wife.

☐ **4.** A 60-year-old woman diagnosed with chronic obstructive pulmonary disease who refuses to wear an oxygen mask even though poor oxygenation makes her confused.

88. The nurse judges that a client is ready to be released from seclusion and restraints when the client demonstrates which of the following behaviors?

☐ **1.** Is adequately sedated.

☐ **2.** Struggles less against the restraints.

☐ **3.** Stops swearing and yelling.

☐ **4.** Shows signs of self-control.

89. Despite education and role-play practice of restraint procedures, a staff member is injured when actually restraining a client. When helping the uninjured staff deal with the incident, the nurse should address which of the following about the injured member?

☐ **1.** The emotional responses may be similar to those of other crime victims.

☐ **2.** The member is likely to resign after experiencing such an injury.
☐ **3.** Legal action against the client will take time and energy.
☐ **4.** The member must debrief with the assaultive client before returning.

90. A nurse calls the unit manager to report that her purse has been stolen from the locked break room. The nurse says she thinks she knows which of the staff stole the purse. Which of the following actions by the nurse manager would be appropriate? Select all that apply.

☐ **1.** Confront the person the nurse suspects stole the purse.
☐ **2.** Call hospital security to initiate an investigation.
☐ **3.** Ask the nurse to document all the facts related to the stolen purse.
☐ **4.** Alert nursing administration that a staff's purse has been stolen.
☐ **5.** Ask other staff to report any suspicious activity they may have observed.

91. A nurse's ex-boyfriend enters the unit and states, “If I can't have her, then no one will.” Hospital security escorts him out of the building and warned him not to return. The unit manager held a staff meeting to confirm that which of the following workplace violence policies and procedures will be implemented? Select all that apply.

☐ **1.** Give a quick overview of the hospital's workplace violence policies and procedures.
☐ **2.** Offer counseling for the nurse threatened by her ex-boyfriend.
☐ **3.** Work with security and the nurse to initiate workplace precautions related to the ex-boyfriend.
☐ **4.** Ask security to help the nurse understand how to initiate a protective order against her ex-boyfriend.
☐ **5.** Ask the nurse to take a leave of absence until her ex-boyfriend is notified of the protective order.

Answers, Rationales, and Test-Taking Strategies

The answers and rationales for each question follow below, along with keys ( *) to the client need (CN) and cognitive level (CL) for each question. As you check your answers, use the* ***Content Mastery and Test-Taking Skill Self-Analysis*** *worksheet (tear-out worksheet in back of book) to identify the reason(s) for not answering the questions correctly. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21 and pages 31–32 in Part 1 of this book.*

The Client Managing Stress

1. 4. The client expressing doubts about his wife's response to his amputation as well as possible doubt on his part is still struggling with body image issues. Looking forward to participating in walkathons and helping others indicates plans for the future that imply an acceptance of his amputee status. Remembering that his friend died in the accident that caused his amputation indicates that the client is aware that there was a worse end result to the accident than his amputation.

 CN: Psychosocial integrity; CL: Evaluate

2. 2. A short explanation followed by quick completion of the procedure minimizes anxiety. The client may be fearful of pain, and assuring him that there will be no pain offers false reassurance. A demonstration may cause increased anxiety. Informing the client that his feelings are common normalizes anxiety and puts the client more at ease, but it is not the most reassuring approach.

 CN: Psychosocial integrity; CL: Synthesize

3. 1. Anxiety, especially at higher levels, interferes with learning and memory retention. After the client's anxiety lessens, it will be easier for him to learn the steps of the blood glucose monitoring. Because the client's illness is a chronic, lifelong illness that severely changes his lifestyle, it is unlikely that he is uninterested in the illness or how to treat it. It is also unlikely that dementia would be the cause of the client's frustration and lack of memory. The client's response indicates anxiety. Client responses that would indicate lessening anxiety would be questions to the nurse or requests to repeat part of the

instruction.

CN: Psychosocial integrity; CL: Analyze

4. 3. An explanation of what to expect decreases anxiety about upcoming events that could be seen as traumatic by the client. Distraction, such as with games or television, only decreases anxiety temporarily and does not fulfill the client's need for information about the procedure. Reassurance about an uncomplicated outcome is not appropriate; the nurse cannot guarantee that the client will come through surgery without problems. Referring the client to a psychiatrist is not indicated for moderate, expected preoperative anxiety.

CN: Physiological adaptation; CL: Synthesize

5. 3. With mild anxiety, perceptions are accurate. Slight muscle tension reflects a motor response. Occasional irritability is an emotional response. Loss of contact with reality is a cognitive characteristic of severe anxiety.

CN: Physiological adaptation; CL: Analyze

6. 1. Suicide attempts and violence are psychomotor responses to a panic level of anxiety. Desperation and rage are emotional responses. Disorganized reasoning and loss of contact with reality are cognitive responses.

CN: Physiological adaptation; CL: Analyze

7. 2. Mild anxiety motivates the client to focus on issues and resolve them. Therefore, learning and problem solving can occur at a mild level of anxiety. Taking control for the client is reserved for a near-panic level of anxiety. Severe anxiety interferes with reasoning and functioning. Therefore, reducing stimuli and pressure is crucial at a severe level. Tension reduction is appropriate at a moderate level to help the client think more clearly and engage in problem solving.

CN: Physiological adaptation; CL: Analyze

8. 4. Minimal functioning, causing new problems to develop, is a reflection of dysfunctional coping. The ability to objectively and rationally problem solve demonstrates adaptive coping. Tension reduction activities demonstrate palliative coping. However, such activities alone do not solve problems; they must be followed by problem solving. Anger management alone may prevent new problems, such as violence toward oneself or others, but it does not solve problems directly. It is considered maladaptive coping.

CN: Physiological adaptation; CL: Analyze

9. 4. Because relationships inherently lead to stress and anxiety, conflict

resolution skills are essential for solving relationship problems. Dealing with anger is more effective than suppressing it. Suppression is a mechanism that avoids the issue rather than solving it. Balancing a checkbook involves calculations, not coping skills. Following directions is a passive activity that reflects a lack of problem solving by the client.

 CN: Psychosocial integrity; CL: Analyze

10. 4. The client's statement that he and his wife listen to each other reflects improved efforts at communicating about issues. The other statements provide some insight into the need for better communication. However, they are but steps along the way to coping effectively with the problem.

 CN: Psychosocial integrity; CL: Evaluate

11. 1. Assessment examines the client's thoughts, feelings, and behaviors within a context. Whether the client's behavior is appropriate for the situation is important assessment data. Setting priorities is part of making nursing diagnoses and planning; motivation to change and identifying the need for a no harm contract are part of the planning stage.

 CN: Psychosocial integrity; CL: Analyze

12. 3. Writing a list of strengths and needs is short-term, achievable, and measurable. Achieving positive self-esteem would occur over the long term. Going to school involves complex future steps to a long-term goal. Using skills is likely to be stressful and is best attempted after the client has done a self-assessment.

 CN: Psychosocial integrity; CL: Synthesize

13. 4. The ultimate outcome is to have the client solve problems by himself, collaborating in his own care. Client follow-up with the psychiatrist, while desirable, does not ensure that the client will fully comply with treatment or medication. Knowledge of the medication's effects and adverse effects and compliance can help the client but alone will not ensure success unless the client knows how to address and solve problems without help from others.

 CN: Health promotion and maintenance; CL: Synthesize

14. 1. Substituting rational beliefs is a major goal when using cognitive-behavioral models, which focus more on thinking and behaviors than feelings. Unconscious processes are the focus of psychoanalytic models. Analysis of fears and barriers to growth is the focus of developmental models. Tension and stress are targets of the stress models.

 CN: Psychosocial integrity; CL: Apply

15. 3. Displacement refers to a defense mechanism that involves taking feelings out on a less-threatening object or person instead of tackling the issue or problem directly. Talking to his wife directly reflects insight into the client's use of the defense mechanism and his ability to overcome it. Not thinking about the weekend is suppression. Here, the client is focusing on the issue with the highest priority. Focusing on academic rather than athletic achievement is compensation, highlighting one's strengths instead of weaknesses. Not remembering the molestation is repression.

 CN: Psychosocial integrity; CL: Evaluate

16. 3. Legally, there is a duty to warn a potential victim of a client's intent to harm. Staff can be held accountable if the client injures the ex-partner and the staff failed to warn that person. The client's permission is needed to share information with a spouse. Only client initials are used in student papers. Release of information is made directly to the client's insurance company, not to the employer.

 CN: Management of care; CL: Apply

17. 2, 5. The client is showing increased anxiety and anger as well as refusing to stay in the hospital, which are immediate and crucial concerns at admission. The client is not likely to give permission to talk to his wife and boss at this point. Housing issues and divorce counseling may be relevant before discharge, but not initially. Suspiciousness and grandiosity may be relevant after the client's anxiety and anger are under control.

 CN: Management of care; CL: Create

18. 2. The nurse is required to set limits on inappropriate behavior while conveying respect and acceptance of that person. Doing so conveys to the client that he is worthy without posing any harm or embarrassment to the client. Touch is a complex issue that must be used cautiously. Touch may be misinterpreted or misperceived by a client who has been abused or who has perceptual or thought disturbances. Mutual sharing reflects a social friendship, not a therapeutic one. Total confidentiality is not desirable. For example, treatment team members and insurance companies need selected information to ensure quality services.

 CN: Psychosocial integrity; CL: Apply

19. 2. Growth of the fetus is important, so nausea and anorexia that would interfere with the young woman's nutrition would cause the most harm to the developing fetus. It could also lead to electrolyte imbalance if she did not take in enough fluid. While insomnia could cause problems long-term, this side effect

could be mitigated through adjustment of the dosing time (earlier in the day) or decrease of the dosage to her former 20 mg daily or even every other day dosing of 40 mg since Prozac has a long half-life. Headaches are uncomfortable but can be treated with mild analgesics or other treatments such as cold cloths that would not harm the fetus. Decreased libido, while not enjoyable for the client or her sexual partner, does not pose any risks for the fetus.

 CN: Pharmacological and parenteral therapy; CL: Analyze

20. 3. Asking for descriptions of changes in behavior (what the client did differently) encourages evaluation. Conveying empathy, such as stating that it is still hard for the client to talk about it, encourages data collection. Asking for meaning helps with the nursing diagnosis. Asking the client about what her husband said the previous night is part of evaluation.

 CN: Psychosocial integrity; CL: Apply

21. 1. With the shorter lengths of stay, the processes and goals of a particular stage are chosen according to the client's current needs and abilities. Building trust (orientation stage) is a priority with psychotic and suspicious clients. It is less crucial for the client ready to work on issues. Making referrals (termination stage) is appropriate for all clients regardless of their needs. The other needs will be addressed in counseling after discharge. Teaching skills (working stage) is appropriate for clients with insight and readiness for change. They may not be appropriate for clients with severe psychosis or suspiciousness, especially if denial is present.

 CN: Management of care; CL: Apply

22. 4. Practicing new behaviors builds confidence and reinforces appropriate behaviors. Reality testing, asking about fears, and teaching new communication skills are some of the many steps when trying out new behaviors.

 CN: Psychosocial integrity; CL: Apply

The Client Coping with Physical Illness

23. 4. While the client does have a right to accept or reject treatment, she has not explored her feelings, her possible mastectomy, or the future. The nurse should assist the client in exploring her feelings and moving toward a fuller understanding of her options. Giving the client survival rates indicates that the nurse feels she should have the surgery and negates her fears and concerns. While the chaplain might be helpful, this step should be done after the client has explored her feelings.

CN: Management of care; CL: Synthesize

24. 2. Diagnosis of a serious illness would be a shock to anyone but particularly a young person. Feelings of anger are normal and should be expressed. Gaining an intellectual understanding of his illness would also be necessary, but such learning will not take place if the client's feelings have not been addressed. There is no indication that the client needs to conserve energy because of his condition, nor is it clear that death is imminent. Neither situation is likely at the point of first diagnosis unless the disease is well advanced, which is not indicated here.

CN: Management of care; CL: Apply

25. 2. The psychotropic drugs used to treat chronic mental illnesses have side effects that can lead to noncompliance. Therefore, teaching the clients measures to deal with the common side effects would be most important. Teaching should be focused on the need for compliance and the specific interests of the target audience. Teaching should concentrate on the medications commonly used to treat chronic mental illness, not on many psychotropic drugs or those used in acute illness. Such topics as the role of medication in the treatment of chronic mental illness and the effects of using common street drugs with psychotropic medication should be discussed after the issue of compliance is addressed.

CN: Health promotion and maintenance; CL: Create

26. 2. When the client seems to be questioning the primary health care provider's goals, it is best for the nurse to present an open statement and ask the client what he means. This technique helps the client express his feelings. Telling the client about the surgery is less therapeutic when he is upset. Chastising the client and defending the primary health care provider are likely to inhibit communication about the client's needs and feelings. Making assumptions can also interfere with communication, especially if the assumption is incorrect.

CN: Psychosocial integrity; CL: Synthesize

27. 2. When the client has hostile outbursts, it is best for the nurse to help her express her feelings. This serves as a release valve for the client. Offering positive reinforcement for cooperation does not help the client express herself appropriately. Continuing with assigned tasks ignores the client's feelings and may lead to further escalation. Encouraging the client to direct anger to the staff is inappropriate. The client needs to express her feelings appropriately.

CN: Psychosocial integrity; CL: Synthesize

28. 3. Preoperative visits and talks with others who have made successful

adjustments to colostomies are helpful and tend to make the client less fearful of the operation and its consequences. Knowing about resources in the community will be helpful as the client approaches discharge. Supporting the primary health care provider is less important than supporting the client and giving him information. The client will have a change in body image, with disfigurement due to the creation of a colostomy. However, the client should be able to lead a full life.

 CN: Management of care; CL: Apply

29. 2. The nurse must present reality to the client about his condition to help decrease his denial about his physical status. By stating the name of the condition and talking about what it means, the nurse provides the client with information and conveys concerns about him and a willingness to help him understand his illness. It may not be true that the client would be made more upset by the call; the news might be good. However, this statement does not provide the client with the reality of his condition. Telling the client that he really doesn't care or asking the client if he realizes that he has a life-threatening condition is belittling and may make the client defensive.

 CN: Psychosocial integrity; CL: Synthesize

30. 1. Leaving the hospital and immediately flying to a meeting indicate poor judgment by the client and little understanding of what she needs to change regarding her lifestyle. The other statements show that the client understands some of the changes she needs to make to decrease her stress and lead a more healthy lifestyle.

 CN: Psychosocial integrity; CL: Evaluate

31. 1, 3, 5. Suicide is a risk with chronic illnesses. The husband needs validation of his feelings and support, as well as suggestions for helping his wife with her concerns. Telling him to be strong and optimistic ignores the client's needs. It is false to assume that the client will no longer be suicidal when the lupus is under control.

 CN: Safety and infection control; CL: Synthesize

32. 4. The nurse's best response is one that directly expresses the nurse's observations to the client and offers the client the opportunity to talk about his feelings or concerns to decrease somatization (the need to express feelings through physical symptoms). Leaving, offering to provide pain medication, and stating that anger does not bother the nurse ignore the client's needs.

 CN: Psychosocial integrity; CL: Synthesize

33. 4. Though ulcerative colitis and OCD have some features in common, and stress can make both illnesses worse, there is no definitive cause-effect relationship between ulcerative colitis and OCD. Therefore, the only appropriate nursing response would be to acknowledge the effect of stress on both illnesses and indicate there is no proof that either illness causes the other.

 CN: Physiological adaptation; CL: Synthesize

34. 4. This type of behavior illustrates *emotional lability,* which is a readily changeable or unstable emotional affect. *Neologism* is using a word when it can have two or more meanings, or a play on words. *Confabulation* involves replacing memory loss by fantasy to hide confusion; it is unconscious behavior. *Flight of ideas* refers to a rapid succession of verbal expressions that jump from one topic to another and are only superficially related.

 CN: Psychosocial integrity; CL: Analyze

35.

2. “Please put the telephone down so we can talk.”
3. “I can hear how upset you are about the cancer.”
1. “Tell me what you are feeling right now.”
4. “I wonder if you would like to talk to a clergyman.”

The first priority is a safe environment so the client and nurse are not hurt by the phone. Then, it is important to acknowledge the client's anger to help diffuse it. As the client calms down, the nurse can explore the client's feeling in more depth. Since the client implies anger at God, a clergy consult may be appropriate.

 CN: Safety and infection control; CL: Analyze

36. 3. Focusing on enjoying time with family and friends conveys a renewal of hope for the future and a decreased risk of suicide. Simply saying that no one wants him to commit suicide does not say he doesn't want to do it. Avoiding a transfer to a psychiatric unit does not mean he is no longer suicidal. Fear of not being successful with suicide usually is not a deterrent.

CN: Reduction of risk potential; CL: Evaluate

The Client in Crisis

37. 3. Individuals progress through the stages of loss at their own pace. Not everyone experiences each phase, and no one can be forced to advance to the next stage until ready. The overall goal for helping the client to work through the pain of loss is to assist the client in processing and engaging in the pain of loss. This process may involve working on family conflicts and/or anger issues but is not the primary goal.

CN: Health promotion and maintenance; CL: Create

38. 1, 2, 3, 6. The immediate needs for this client are for safety and security, so it is important to assess for injuries, safety of her family, suicide risk, and signs of emotional decompensation. Needs for food, clothing, and support are important later, after safety and security are addressed.

CN: Reduction of risk potential; CL: Analyze

39. 2. During the first phase of crisis, the client exhibits elevated anxiety. A client who can use problem-solving capabilities is not in crisis. A shortened attention span is characteristic of the fourth phase of crisis. Reaching out to others for help is indicative of the third phase of crisis.

CN: Management of care; CL: Synthesize

40. 3. Before any interventions can occur, knowing whether the client is pregnant is crucial in formulating a plan of care. Asking the client about what things she had thought about doing, giving the client some ideas about what to expect next, and questioning the client about her feelings and possible parental reactions would be appropriate after it is determined that the client is pregnant.

CN: Psychosocial integrity; CL: Synthesize

41. 2. Because of the client's potential pregnancy, the nurse needs to determine exactly what the client means by the term “hooking up” by asking the client to describe what she has been doing in sexual encounters with her boyfriend. Asking the client if she means sexual intercourse or telling the client that they need to talk about sexual intercourse makes an assumption that may or may not be appropriate. The nurse needs to determine exactly what the client means by the terms used. Repeating the client's statement does not elicit the necessary information to interpret the client's statement. Additionally, this type of response assumes an understanding of what the client has said.

CN: Psychosocial integrity; CL: Synthesize

42. 4. Because people in an emotional crisis find it difficult to focus their thinking, the goal is to return the client to noncrisis functioning. Pointing out and decreasing the client's level of anxiety is the first step in attaining this goal. Telling an obviously distressed person not to worry is ineffective because it ignores the client's distress and concerns. Although pregnancy is a normal event, and 40 years of age may not be too old for a pregnancy, these responses also ignore the client's distress and feelings.

 CN: Psychosocial integrity; CL: Synthesize

43. 1. Telephoning the crisis shelter indicates that the boys are alarmed but are reluctant to talk with their parents. The boys may fear that their parents will assume that they have been sniffing glue and punish them. The nurse should focus on helping the boys talk with their parents. Although sniffing glue is dangerous and potentially lethal, it is not illegal. To prove that the observations are incorrect requires an intervention beginning with the boys' parents. Sniffing glue is included in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revised, as inhalant abuse. It is not a minor form of substance abuse.

 CN: Management of care; CL: Synthesize

44. 1. The crisis worker needs to use active focusing techniques to determine the crisis-precipitating event or the immediate problem. Asking the caller, “Why are you calling today?” or “What is the immediate problem?” will assist the caller to focus on the specific need or event. Telling the client to make an appointment is inappropriate because the problem might be life threatening. Telling the caller to go to the nearest emergency room is precipitous and may be unnecessary. Asking to speak to someone else in the home may be futile because the caller might be alone. This action also ignores the caller and his or her feelings.

 CN: Management of care; CL: Synthesize

45. 3. The concern that someone may call the crisis hotline every day for a year indicates that further understanding about crisis and crisis intervention is needed. A crisis situation is time-limited, typically resolving in 4 to 6 weeks if handled effectively. If a person calls the line daily for a year, that person has not been properly dealt with or is probably in a highly disorganized state requiring an alternative intervention. The nurse needs to further review and clarify the material presented. Callers are typically in pain, overwhelmed, and exhausted when they call. A crisis can help an individual cope better in the future if he learns to handle the situation.

CN: Management of care; CL: Evaluate

46. 2, 3, 4, 5, 6. Controlling self-destructive behaviors is a priority, but developing emotion management skills and processing emotions and memories are also important. Assessing for injuries, pregnancy, STDs, and drugs in her system is important due to the fact that most cults foster sex and pregnancy in young teens and often use drugs to achieve compliance from the girls. It is not appropriate to ask the client to share her experiences in a group of teens. It could be more damaging to the client unless the other teens are also trauma/torture survivors.

CN: Psychosocial integrity; CL: Synthesize

47. 2. Generally, 4 to 6 weeks is viewed as the length of time a client can tolerate the severe level of disturbance of a true crisis. In the first week or two, the client usually is still trying to use normal coping skills and support systems. After 6 weeks of continuous crisis, a client is probably becoming so physically and emotionally drained that he has sought or has been brought by others for medical or psychiatric care.

CN: Management of care; CL: Apply

48. 1. The initial goal in crisis intervention is helping the client regain emotional security and equilibrium. Resolution of the underlying emotional problems, development of insight and personal growth, and formulation of more effective support systems are goals to address as the crisis subsides.

CN: Psychosocial integrity; CL: Apply

49. 3. Learning new coping skills is the major factor necessary for higher functioning. Better coping is likely to lead to regaining support systems, giving up dysfunctional coping, and awareness of how to prevent future crises.

CN: Psychosocial integrity; CL: Apply

50. 3. The risk of suicide can persist for 2 to 3 months even after a crisis has abated. Therefore, it is important for the client to be able to verbalize information about appropriate support persons and community resources and to have this information readily available. Although the client may state that she is ready to be discharged, this is not the most reliable indicator. A divorce lawyer may not be appropriate at this point. At 3 days after a suicide attempt, emotional stability is not likely.

CN: Management of care; CL: Evaluate

51. 4. The statement about joining the son if he dies indicates potential for

self-harm and subsequent suicide, always a risk during crisis. Although the father may be charged with reckless driving, this is not an indication for a psychiatric consultation. Although the son's mother may be extremely upset and angry about the event, this statement is more likely an overstatement, not a real risk. The statement about not seeing the son run behind the car illustrates the father's attempts at trying to process the situation.

 CN: Psychosocial integrity; CL: Evaluate

52. 1. Passive suicidal thoughts, such as a wish to die or giving up on self-care, can be as much of a risk as active suicidal ideation (the idea of killing one's self directly), especially for older clients because they commonly lack the means, energy, and motivation for an active suicide attempt. Seeing the grandson and grandmother together may help later. Not talking to the grandson and experiencing altered role performance may be real issues, but these are not as critical as the risk of indirect (passive) suicide.

 CN: Psychosocial integrity; CL: Analyze

53. 2. The threat toward the ex-boyfriend is the most immediate concern now, as the client turns her anger toward him instead of herself. Although situational low self-esteem, risk for suicide, and risk-prone health behavior are accurate, these problems are less of a concern at this time.

 CN: Safety and infection control; CL: Analyze

54. 3. Letting the client express his feelings (emotion management) is essential before trying to problem solve about the situation or deciding what kind of referral is appropriate. A referral for counseling, assessment of the client's support system, and unemployment assistance may be appropriate after the client's anxiety is reduced.

 CN: Psychosocial integrity; CL: Apply

55. 2. During a crisis, support persons demonstrate preparedness to help the client by verbalizing the emergency resources available and knowing when to use them. Follow-up medical care may be helpful as the crisis subsides. The coping strategies used by the support persons may or may not be relevant to the client's needs and situation. Long-term solutions and advice may or may not be appropriate. The focus needs to be on the client's immediate needs and situation.

 CN: Psychosocial integrity; CL: Analyze

56. 1. The nurse needs to focus on the client and address her feelings. Talking about her feelings helps to decrease the risk of self-harm. Doing so takes precedence over questions about the husband's estate, the cause of death, and her

children's support.

CN: Psychosocial integrity; CL: Synthesize

57. 1, 2, 3, 4, 5. All of the options are correct and in an appropriate sequence of actions except for option 6. The flyover is likely to trigger vivid memories and emotions in those living near the city related to the tragedy of the Twin Towers on 9/11/01. The severity of the flashbacks will vary in degree, just as they did after the original event. Asking the military for an apology will not address the caller's symptoms.

CN: Management of care; CL: Synthesize

The Client with Problems Expressing Anger

58. 4. Beginning with a broad opening statement that brings out the client's view of his situation and reasons for seeking treatment is the most neutral beginning and helps to gain the client's perception of events. Blaming the client for his problems is accusatory and nonproductive. A time for reviewing what could be done differently will come later.

CN: Psychosocial integrity; CL: Apply

59.

2. “Anger is a natural emotion occurring in all human relationships.”
4. “Unexpressed anger has a negative effect on the human body and mind.”
3. “Holding your anger inside contributes to your depression.”
1. “You can learn effective ways to discuss anger with others and still maintain control.”

The clients need to understand that anger is a normal emotion, but if not expressed can have negative effects on the body and mind. Then, the nurse begins to focus on the client's personal situation and that holding anger in aggravates his depressive symptoms as well. One focus of outpatient counseling will be learning safe, effective ways to express anger.

CN: Reduction of risk potential; CL: Analyze

60. 3. It is unlikely that the primary health care provider would imply that the client should be more aggressive. Denial of anger with passive, unassertive behavior and the aggressive expression of anger are dysfunctional behavior patterns. Gender-based stereotypes are not conducive to mental health, and deeming assertive behavior in women as culturally unacceptable interferes with the goal of developing assertiveness skills. Group acceptance should not be based on whether a client is demonstrating assertive or aggressive behavior.

 CN: Psychosocial integrity; CL: Apply

61. 1, 2, 3, 5. Dealing with anger, stress, and anxiety; identifying resources and support groups; and increasing a sense of safety and security are appropriate interventions at this time. However, recommending an antiwar advocacy group may or may not be appropriate, even much later in the client's recovery.

 CN: Psychosocial integrity; CL: Synthesize

62.

2. Helping the client identify triggers for his anger.
1. Assisting the client to recognize the early cues that he is angry.
4. Identifying alternate ways to express his anger.
3. Practicing with the client appropriate ways to express his anger.

Angry clients may not realize what makes them angry and the cues that their behavior is becoming out of control. The nurse should first help the client identify what triggered the anger. Once the cause of the anger and cues to the loss of control are discovered, the nurse should assist the client in identifying safe and appropriate alternative expressions of anger and then practice those techniques prior to facing a real anger-producing situation.

 CN: Psychosocial integrity; CL: Synthesize

63. 3. By requesting that the roommate respect his rights (asking the roommate to put the dirty clothes on the floor away after telling him that this bothers him), the client is asserting himself. Arriving late is commonly passive resistance and thus not an indicator that the client is becoming assertive. Asking

the nurse to call is dependent behavior. Although asking the doctor is more assertive, the client is relying on the nurse's direction to do so.

 CN: Psychosocial integrity; CL: Analyze

64. 2. Blood pressure, as well as respiratory rate and muscle tension, increases during anger because of the autonomic nervous system response to epinephrine secretion. Peristalsis also decreases.

 CN: Physiological adaptation; CL: Apply

65. 3. Fear of harm is a common response to anger in clients who lack coping skills and assertiveness. Decreased self-esteem is common because most clients are aware that they have difficulty in responding to anger effectively. Although anger may provide an initial feeling of strength and invulnerability, this is rarely a sustained response. Powerlessness more commonly leads to anger, rather than resulting from it.

 CN: Psychosocial integrity; CL: Apply

66. 4. When given intramuscularly, haloperidol is considered most restrictive because it is intrusive and a client usually does not receive the drug voluntarily. Oral haloperidol is considered less restrictive because the client usually accepts the pill voluntarily. Tension reduction strategies and voluntary seclusion are considered less restrictive because they are not intrusive and the client usually consents to their use.

 CN: Safety and infection control; CL: Apply

67. 2. Asking the staff for assistance is appropriate when the client demonstrates behaviors that involve the direct threat of violence. Holding a stick and telling the nurse to move is the most direct threat of violence. Swearing and pounding on a table may be disturbing, but these actions are less of a threat. Coming out of his room may indicate noncompliance with directions. However, further assessment is needed to determine whether this behavior was a direct threat of violence.

 CN: Management of care; CL: Analyze

68.

3. “Remove yourself to a quiet environment.”

4. “Tell trusted people that you are becoming upset.”

1. “Take your oral lorazepam (Ativan).”

2. “Take your oral haloperidol (Haldol).”

Since external stimuli can greatly contribute to agitation, the nurse should teach the client that the first step is to go to a quiet area, then enlist the help of others, and finally take medication. Taking the lorazepam first of the two medications would help decrease anxiety quickly, thus diminishing agitation. If the lorazepam is not successful, the client could take the oral haloperidol to help clear the client's thoughts and decrease agitation.

 CN: Management of care; CL: Synthesize

69. 3. The client who is about to lose control is experiencing a high degree of anxiety or agitation, which alters the client's ability to perceive reality. Initially, the client may feel threatened by the presence of others. A client who is out of control is not thinking about having an audience. Although the nurse with the client who is about to lose control is generally the one giving directions, this is not a rationale for staying at a distance. When seeing extra staff, the client may or may not be able to gain self-control.

 CN: Safety and infection control; CL: Apply

70. 1. When using seclusion, the safety of the client is paramount. Therefore, staff must be able to see the client in seclusion at all times, such as through a security window in the door or with a room camera. Although outside access for dimming the lights to decrease stimuli may be appropriate, it is not critical for the client's safety. Having one staff member stay in a room alone with a potentially violent client is unsafe. A doctor's prescription for seclusion can be obtained before or after it is initiated.

 CN: Safety and infection control; CL: Synthesize

71. 3. A full-length restraint blanket is added when the client is at risk for injury from fighting the restraints. The increased degree of restriction is justified only when the risk of client injury increases. Feeling more secure is not a sufficient cause for using a more restrictive measure. Client statements that restraints are tight and uncomfortable require the nurse to assess the situation and adjust the restraints if necessary to ensure adequate circulation. Four-way restraints already provide adequate protection for the staff.

 CN: Safety and infection control; CL: Apply

72. 1. Safety of the client and staff is the utmost priority. Therefore, the client must be monitored closely and frequently, such as every 15 minutes, to ensure that the client is safe and free from injury. Assisting with nutrition and elimination, performing range-of-motion exercises on each limb, and changing the client's position every 2 hours are important after the safety of the client and staff is ensured by close, frequent monitoring.

 CN: Safety and infection control; CL: Synthesize

73. 4. The long-term goal of the debriefing after restraining a client is to improve aggression management procedures so that prevention of aggression improves and the frequency of restraint use decreases. Providing feedback and comparing perceptions are single aspects that would eventually lead to the ultimate goal of improving aggression management procedures. When a client can be released from restraints is not immediately predictable.

 CN: Management of care; CL: Synthesize

The Client with Interpersonal Violence

74.

2. Calmly restate to the client and his brother that the client cannot be released without a primary health care provider's prescription.

4. Ask the client's brother to leave the unit quietly when he repeats his demands.

3. Quietly ask the other clients and visitors to move to another area of the unit with a staff member.

1. Call security officers to the unit for the protection of all on the unit.

The first step is to calmly present the reality that the client cannot be released at this time. Next, the brother should be asked to leave the unit quietly. When he does not, protecting the other clients and visitors is essential for their safety. (The staff member can help them process what is happening on the unit.) Calling security to the unit is a last resort when less restrictive measures have not worked. Calling them, before setting limits with the brother and giving him a

choice of actions, will likely escalate the situation. Security can legally escort the brother off the unit and hospital grounds.

 CN: Safety and infection control; CL: Create

75. 4. Verbalizing feelings, especially feelings of anger, in an appropriate manner is an adaptive method of coping that reduces the chance that the client will act out these feelings toward others. The client's ability to verbalize her feelings indicates a change in behavior, a crucial indicator of goal achievement. Although acknowledging feelings of anger and describing situations that precipitate angry feelings are important in helping the client reach her goal, they are not appropriate indicators that she has changed her behavior. Asking the client to list how she has handled anger in the past is helpful if the nurse discusses coping methods with the client. However, based on this client's history, this would not be helpful because the nurse and client are already aware of the client's aggression toward others.

 CN: Safety and infection control; CL: Evaluate

76. 3. The nurse must clearly address behavioral expectations, such as telling the client that hitting is unacceptable, and also provide alternatives for the client, such as letting staff members know when he begins to feel angry. Making others responsible for the client's behavior or isolating the client in his room is inappropriate because it does not include the client in managing his behavior. Although medication may be helpful, this action does not give the client responsibility for his behavior and is not warranted at this time.

 CN: Safety and infection control; CL: Synthesize

77. 4. The client is in the crisis phase of the assault cycle. Therefore, the nurse must act immediately, using restraints and an intramuscular tranquilizer to prevent injury to others or further property damage. It is too late to ask the client to go to a quiet area to talk because the client's behavior is past the triggering phase. Giving the client an oral tranquilizer and preparing for a show of determination are nursing interventions used in the escalation phase. Processing the incident with the client and discussing alternative behaviors are interventions used in the postcrisis phase.

 CN: Safety and infection control; CL: Synthesize

78. 1, 3, 5. Survivors of torture and ritual abuse typically have intense feelings, including mixed emotions about the abusers, anger, rage, and guilt. With self-destructive behavior, they need ways to handle these urges, such as dealing with ambivalent feelings, determining alternatives to self-destructive

behaviors, and developing safe ways to deal with rage and guilt. Confrontation with the abusers is not necessarily appropriate. Filing criminal charges is not likely due to the statute of limitations.

 CN: Psychosocial integrity; CL: Synthesize

79. 1. The nurse should respond to the husband's needs and concerns and should offer support. Protecting or defending the wife against his criticism ignores the husband's needs.

 CN: Psychosocial integrity; CL: Synthesize

80. 3. It is important to know the client's reactions in order to plan appropriate interventions. Until the client's reactions are known, it is premature to suggest a job transfer, file a report to his boss' supervisor, or alert his coworkers.

 CN: Management of care; CL: Synthesize

81. 2, 3, 4. After the impact of a crime, the client's most important needs are for physical safety and emotional security. There is no indication that the client has a severe level of anxiety; therefore, lorazepam is not indicated. Asking her how she could have prevented the robbery implies that she could be at fault.

 CN: Psychosocial integrity; CL: Synthesize

82. 1, 2, 3, 5. Receiving support from family, friends, other survivors, and community services is generally helpful after such events. Relaxation and participation in activities help manage stress reactions. Speaking out publicly may or may not be helpful later in the recovery process but may actually hinder recovery in the early stages.

 CN: Psychosocial integrity; CL: Synthesize

Managing Care Quality and Safety

83. 4. When a client is committed involuntarily, the right to leave against medical advice is forfeited. All the other rights are preserved unless there is further court action or a case of imminent danger to self or others (hitting staff, cutting self).

 CN: Management of care; CL: Apply

84. 4. The primary goal of an aggression management program is to prevent violence. This goal is evidenced by a reduction in the total number of restraint procedures used or needed. Although fewer client and staff injuries are important, these goals are secondary to prevention. Reduction in the number of

complaints by clients' relatives is affected by more variables than just restraint procedures.

 CN: Management of care; CL: Evaluate

85. 1, 2, 3, 4. The crucial interventions involve safety and support. Asking for consent is a health privacy issue, not a safety issue, and is not essential to the discharge process.

 CN: Safety and infection control; CL: Synthesize

86.

1. Initiate suicide precautions and a no harm contract.
3. Offer empathy and support and be nonjudgmental and honest with her.
4. Encourage safe verbalizations of her emotions, especially anger.
2. Ask the client if she wishes to contact her family while hospitalized.

Safety is a priority after the client stabbed herself. A survivor of trauma/torture needs empathy, support, honestly, and a nonjudgmental stance from the nurse. Then the client is more willing to learn safe ways to express feeling, especially anger. It will be the client's decision if she wants to contact her family and, if so, under what conditions. She would need extensive preparation before any contact with her family.

 CN: Safety and infection control; CL: Synthesize

87. 4. The 60-year-old woman is acting in a way that worsens her physical and mental condition because she does not want to be sick. The 8-year-old child is acting normally for someone his age who is unexpectedly hospitalized. The cooperation demonstrated by the client with lupus and the client who had a myocardial infarction indicates a level of acceptance of their illnesses and of their role as being ill.

 CN: Management of care; CL: Analyze

88. 4. The client is ready to be released from restraints when he shows signs of self-control, decreased anxiety and agitation, reality orientation, mood stabilization, increased attention span, and judgment. Adequate sedation,

struggling less against restraints, and not swearing and yelling are not adequate signs of being calm and in control.

 CN: safety and infection control; CL: Evaluate

89. 1. Being injured by a client can result in emotional responses similar to those of other crime victims. A resignation after being injured is relatively rare. Legal action against the client is sometimes discussed but rarely initiated. Debriefing with the client may be inappropriate or unnecessary to resolve the situation.

 CN: Management of care; CL: Synthesize

90. 2, 3, 4, 5. It is appropriate for the nurse manager to initiate a security investigation and ask the nurse to document all the facts about the missing purse. Alerting nursing administration is required. Seeking information from other staff will help with the investigation. It is inappropriate to confront any possible suspects while the investigation is ongoing.

 CN: Management of care; CL: Analyze

91. 1, 2, 3, 4. National guidelines exist for managing workplace violence. Unit staff, hospital administration, and hospital security personnel develop and enforce the resulting policies. These include training all staff about workplace violence, processes for reporting of such violence, and counseling for the staff victim. Protecting staff and clients may include posting the ex-boyfriend's picture at employee entrances and a protective order initiated by the nurse. With these policies and procedures in place, it is counterproductive to ask the nurse to take a leave of absence.

 CN: Management of care; CL: Analyze

TEST 5: Abuse and Mental Health Problems of Children, Adolescents, and Families

The Client Experiencing Abuse

1. A married female client has been referred to the mental health center because she is depressed. The nurse notices bruises on her upper arms and asks about them. After denying any problems, the client starts to cry and says, “He didn't really mean to hurt me, but I hate for the kids to see this. I'm so worried about them.” Which of the following is the most crucial information for the nurse to determine?

☐ **1.** The type and extent of abuse occurring in the family.
☐ **2.** The potential of immediate danger to the client and her children.
☐ **3.** The resources available to the client.
☐ **4.** Whether the client wants to be separated from her husband.

2. A client with suspected abuse describes her husband as a good man who works hard and provides well for his family. She does not work outside the home and states that she is proud to be a wife and mother just like her own mother. The nurse interprets the family pattern described by the client as best illustrating which of the following as characteristic of abusive families?

☐ **1.** Tight, impermeable boundaries.
☐ **2.** Unbalanced power ratio.
☐ **3.** Role stereotyping.
☐ **4.** Dysfunctional feeling tone.

3. When planning the care for a client who is being abused, which of the following measures is **most** important to include?

☐ **1.** Being compassionate and empathetic.
☐ **2.** Teaching the client about abuse and the cycle of violence.
☐ **3.** Explaining to the client about the client's personal and legal rights.
☐ **4.** Helping the client develop a safety plan.

4. A nurse is assessing a client who is being abused. The nurse should assess the client for which characteristic? Select all that apply.

☐ **1.** Assertiveness.
☐ **2.** Self-blame.
☐ **3.** Alcohol abuse.
☐ **4.** Suicidal thoughts.
☐ **5.** Guilt.

5. After months of counseling, a client abused by her husband tells the nurse

that she has decided to stop treatment. There has been no abuse during this time, and she feels better able to cope with the needs of her husband and children. In discussing this decision with the client, the nurse should:

☐ **1.** Tell the client that this is a bad decision that she will regret in the future.
☐ **2.** Find out more about the client's rationale for her decision to stop treatment.
☐ **3.** Warn the client that abuse commonly stops when one partner is in treatment, only to begin again later.
☐ **4.** Remind the client of her duty to protect her children by continuing treatment.

6. A third-grade child is referred to the mental health clinic by the school nurse because he is fearful, anxious, and socially isolated. After meeting with the client, the nurse talks with his mother, who says, “It's that school nurse again. She's done nothing but try to make trouble for our family since my son started school. And now you're in on it.” The nurse should respond by saying:

☐ **1.** “The school nurse is concerned about your son and is only doing her job.”
☐ **2.** “We see a number of children who go to your son's school. He isn't the only one.”
“You sound pretty angry with the school nurse. Tell me what has happened.”
☐ **4.** “Let me tell you why your son was referred, and then you can tell me about your concerns.”

7. The mother of a school-aged child tells the nurse that, “For most of the past year, my husband was unemployed and I worked a second job. Twice during the year I spanked my son repeatedly when he refused to obey. It has not happened again. Our family is back to normal.” After assessing the family, the nurse decides that the child is still at risk for abuse. Which of the following observations best supports this conclusion?

☐ **1.** The parents say they are taking away privileges when their son refuses to obey.
☐ **2.** The child has talked about family activities with the nurse.
☐ **3.** The parent's are less negative toward the nurse.
☐ **4.** The child wears long-sleeved shirts and long pants, even in warm weather.

8. When caring for a client who was a victim of a crime, the nurse is aware that recovery from any crime can be a long and difficult process depending on the meaning it has for the client. Which of the following should the nurse establish as a victim's ultimate goal in reconstructing his or her life?

☐ **1.** Getting through the shock and confusion.
☐ **2.** Carrying out home and work routines.

☐ **3.** Resolving grief over any losses.
☐ **4.** Regaining a sense of security and safety.

9. A client tells the nurse that she has been raped but has not reported it to the police. After determining whether the client was injured, whether it is still possible to collect evidence, and whether to file a report, the nurse's next priority is to offer which of the following to the client?
☐ **1.** Legal assistance.
☐ **2.** Crisis intervention.
☐ **3.** A rape support group.
☐ **4.** Medication for disturbed sleep.

10. In working with a rape victim, which of the following is **most** important?
☐ **1.** Continuing to encourage the client to report the rape to the legal authorities.
☐ **2.** Recommending that the client resume sexual relations with her partner as soon as possible.
☐ **3.** Periodically reminding the client that she did not deserve and did not cause the rape.
☐ **4.** Telling the client that the rapist will eventually be caught, put on trial, and jailed.

11. In the process of dealing with intense feelings about being raped, victims commonly verbalize that they were afraid they would be killed during the rape and wish that they had been. The nurse should decide that further counseling is needed if the client voices which of the following?
☐ **1.** “I didn't fight him, but I guess I did the right thing because I'm alive.”
☐ **2.** “Suicide would be an easy escape from all this pain, but I couldn't do it to myself.”
☐ **3.** “I wish they gave the death penalty to all rapists and other sexual predators.”
“I get so angry at times that I have to have a couple of drinks before I sleep.”

12. One of the myths about sexual abuse of young children is that it usually involves physically violent acts. Which of the following behaviors is more likely to be used by the abusers?
☐ **1.** Tying the child down.
☐ **2.** Bribery with money.
☐ **3.** Coercion as a result of the trusting relationship.
☐ **4.** Asking for the child's consent for sex.

13. A preadolescent child is suspected of being sexually abused because he

demonstrates the self-destructive behaviors of self-mutilation and attempted suicide. Which common behavior should the nurse also expect to assess?

☐ **1.** Inability to play.
☐ **2.** Truancy and running away.
☐ **3.** Head banging.
☐ **4.** Overcontrol of anger.

14. Adolescents and adults who were sexually abused as children commonly mutilate themselves. The nurse interprets this behavior as:

☐ **1.** The need to make themselves less sexually attractive.
☐ **2.** An alternative to binging and purging.
☐ **3.** Use of physical pain to avoid dealing with emotional pain.
☐ **4.** An alternative to getting high on drugs.

15. A young child who has been sexually abused has difficulty putting feelings into words. Which of the following should the nurse employ with the child?

☐ **1.** Engaging in play therapy.
☐ **2.** Role-playing.
☐ **3.** Giving the child's drawings to the abuser.
☐ **4.** Reporting the abuse to a prosecutor.

16. When working with a group of adult survivors of childhood sexual abuse, dealing with anger and rage is a major focus. Which strategy should the nurse expect to be successful? Select all that apply.

☐ **1.** Directly confronting the abuser.
☐ **2.** Using a foam bat while symbolically confronting the abuser.
☐ **3.** Keeping a journal of memories and feelings.
☐ **4.** Writing letters to the abusers that are not sent.
☐ **5.** Writing letters to the adults who did not protect them that are not sent.

17. After a client reveals a history of childhood sexual abuse, the nurse should ask which of the following questions **first**?

☐ **1.** “What other forms of abuse did you experience?”
☐ **2.** “How long did the abuse go on?”
☐ **3.** “Was there a time when you did not remember the abuse?”
“Does your abuser still have contact with young children?”

18. Which parental characteristic is **least** likely to be a risk factor for child abuse?

☐ **1.** Low self-esteem.
☐ **2.** History of substance abuse.
☐ **3.** Inadequate knowledge of normal growth and development patterns.

☐ **4.** Being a member of a large family.

19. When obtaining a nursing history from parents who are suspected of abusing their child, which of the following characteristics about the parents should the nurse particularly assess?

☐ **1.** Attentiveness to the child's needs.
☐ **2.** Self-blame for the injury to the child.
☐ **3.** Ability to relate the child's developmental achievements.
☐ **4.** Difficulty with controlling aggression.

20. A 3-year-old child with a history of being abused has blood drawn. The child lies very still and makes no sound during the procedure. Which of the following comments by the nurse would be **most** appropriate?

“It's okay to cry when something hurts.”
☐ **2.** “That really didn't hurt, did it?”
☐ **3.** “We're mean to hurt you that way, aren't we?”
☐ **4.** “You were very good not to cry with the needle.”

21. While interviewing a 3-year-old girl who has been sexually abused about the event, which approach would be **most** effective?

☐ **1.** Describe what happened during the abusive act.
☐ **2.** Draw a picture and explain what it means.
“Play out” the event using anatomically correct dolls.
☐ **4.** Name the perpetrator.

22. Which of the following observations by the nurse should suggest that a 15-month-old toddler has been abused?

☐ **1.** The child appears happy when personnel work with him.
☐ **2.** The child plays alongside others contentedly.
☐ **3.** The child is underdeveloped for his age.
☐ **4.** The child sucks his thumb.

23. When planning interventions for parents who are abusive, the nurse should incorporate knowledge of which factor as a common parental indicator?

☐ **1.** Lower socioeconomic group.
☐ **2.** Unemployment.
☐ **3.** Low self-esteem.
☐ **4.** Loss of emotional family attachments.

24. A 15-year-old boy has been shy and quiet throughout his schooling. In the past, he has been teased about being “big” and “fat,” leading him to get angry and fight those who called him names. This school year, he joined the wrestling team and showed some promise, though he had to lose weight to

compete in a lower weight class. This spring his mother called the school nurse and said she had noticed that her son was wearing long-sleeved shirts all the time and spending a lot of time in the bathroom at home. She has seen scars on his wrists that the boy attributes to wrestling although the season has been over for awhile. She and the boy's father are going through a contentious divorce that she thinks may be upsetting her son. In what order of priority from first to last should the school nurse initiate the following actions?

1. Interview the teen about how he is handling the divorce, any bullying he may be experiencing, and his current grades.

2. Interview the mother further about the child's early childhood and any potential antecedents to his current behavior.

3. Interview the father about his awareness of his son's behavior and perspective concerning it as well as the relationship between him and his son.

4. Ask the boy about self-injury, depression, and suicidality in connection with the scars on his wrists.

25. A shy middle school student set up a Facebook page. A popular student sent a message that included a suggestive picture of himself and suggested the student send a similar picture. When the student sent back a picture of himself dressed only in his boxers, the popular student sent it to all his friends and encouraged them to pass it along. Soon the whole school had seen the picture identified as “Joe's Crotch.” The student was so distressed and mortified he tried to hang himself but was found by his parent before he succeeded. Which of the following outcomes would be most realistic and appropriate with regard to this situation? Select all that apply.

☐ **1.** The Facebook privileges of all those who forwarded the message are revoked for a year.
☐ **2.** All students in the school are educated about the risks of cyberbullying and how to respond to it.
☐ **3.** The popular student who sent the message to his friends is disciplined by the school authorities.
☐ **4.** Joe can use the Internet safely after being educated about cyberbullying and completing a safety plan.
☐ **5.** Through therapy, Joe learns social skills to improve his confidence level and help him relate to peers more easily.

The Adolescent With Eating Disorders

26. The nurse is planning an eating disorder protocol for hospitalized clients experiencing bulimia and anorexia. Which elements should be included in the protocol? Select all that apply.

☐ **1.** Clients must eat within view of a staff member.
☐ **2.** Clients are not told their weight and cannot see their weight while being weighed.
☐ **3.** Clients are not allowed to discuss food or eating in groups or informal conversation with peers.
☐ **4.** Clients must rest within view of a staff member and not go to the bathroom for one-half hour to an hour after eating.
☐ **5.** Clients cannot participate in any groups after admission until they gain 1 lb (0.45 kg).

27. A hospitalized adolescent diagnosed with anorexia nervosa refuses to comply with her daily before-breakfast weigh-in. She states that she just drank a glass of water, which she feels will unfairly increase her weight. What is the nurse's **best** response to the client?

☐ **1.** “You are here to gain weight so that will work in your favor.”
☐ **2.** “Don't drink or eat for 2 hours and then I'll weigh you.”
“You must weigh in every day at this time. Please step on the scale.”
☐ **4.** “If you don't get on the scale, I will be forced to call your doctor.”

28. The nurse discovers that an adolescent client with anorexia nervosa is taking diet pills rather than complying with the diet. What should the nurse do **first**?

☐ **1.** Explain to the client how diet pills can jeopardize health.
☐ **2.** Listen to the client about fears of losing control of eating while being treated.
☐ **3.** Talk with the client about how weight loss and emaciation worry the health care providers.
☐ **4.** Inquire about worries of the client's family concerning the client's physical and emotional health.

29. When teaching a group of adolescents about anorexia nervosa, the nurse should describe this disorder as being characterized by which of the following?

☐ **1.** Excessive fear of becoming obese, near-normal weight, and a self-critical body image.

☐ **2.** Obsession with the weight of others, chronic dieting, and an altered body image.
☐ **3.** Extreme concern about dieting, calorie counting, and an unrealistic body image.
☐ **4.** Intense fear of becoming obese, emaciation, and a disturbed body image.

30. When developing a teaching plan for a high school health class about anorexia nervosa, which of the following should the nurse include as the primary group affected by this disease?
☐ **1.** Women, age at onset between 12 and 20 years.
☐ **2.** Men, onset during the college years.
☐ **3.** Women, onset typically after 30 years.
☐ **4.** Men, onset after 20 years.

31. The parents of a newly diagnosed 15-year-old with anorexia nervosa are meeting with the nurse during the admission process. Which of the following remarks by the parents should the nurse interpret as typical for a client with anorexia nervosa?
☐ **1.** “We've given her everything, and look how she repays us!”
☐ **2.** “She's had behavior problems for the past year both at home and at school.”
“She's been a model child. We've never had any problems with her.”
☐ **4.** “We have five children, all normal kids with some problems at times.”

32. A young adult female client and her roommate go the emergency department due to gastrointestinal problems. The client reveals that she attends college and works at a coffee shop each evening. A diet history indicates that the client has unhealthy eating habits, commonly eating large amounts of carbohydrates and junk food with few fruits and vegetables. “Her stomach is upset a lot,” the roommate says. She further reports that the client is “in the bathroom all the time.” The nurse should refer the client to:
☐ **1.** A mental health clinic.
☐ **2.** A weight loss program.
☐ **3.** An overeating support group.
☐ **4.** The client's family primary health care provider.

33. A nurse is working with a client with bulimia. Which of the following goals should be included in the care plan? Select all that apply.
☐ **1.** The client will maintain normal weight.
☐ **2.** The client will comply with medication therapy.
☐ **3.** The client will achieve a positive self-concept.
☐ **4.** The client will acknowledge the disorder.

☐ **5.** The client will never have the desire to purge again.

34. A nurse works with a client diagnosed with bulimia. What is an appropriate long-term client goal for this client?

☐ **1.** Eating meals at home without binging or purging.
☐ **2.** Being able to eat out without binging or purging.
☐ **3.** Managing stresses in life without binging or purging.
☐ **4.** Being able to attend college in another state without binging or purging.

35. While coaching a youth soccer team, the nurse has observed one of the teammates binging and purging on multiple occasions. The nurse asks the girl's mother to stay after practice and talk privately. Which of the following ways is best for the nurse to begin the conversation?

☐ **1.** "Thank you for letting your daughter play on the team. She's a very good player and is also pleasant and easy to coach."
☐ **2.** "I have some very bad news for you. Your daughter has a serious problem that is diagnosed as an eating disorder."
"I am a nurse. I have seen your daughter doing things that are considered to be part of an eating disorder."
☐ **4.** "Let me get right to the point. Your daughter is very sick and needs to see a mental health therapist right away."

36. A client newly diagnosed with bulimia is attending the nurse-led group at the mental health center. She tells the group that she came only because her husband said he would divorce her if she didn't get help. Which of the following responses by the nurse is appropriate?

☐ **1.** "You sound angry with your husband. Is that correct?"
☐ **2.** "You will find that you like coming to group. These people are a lot of fun."
"Tell me more about why you are here and how you feel about that."
☐ **4.** "Tell me something about what has caused you to be bulimic."

37. A client diagnosed with bulimia tells the nurse she only eats excessively when upset with her best friend, and then she vomits to avoid gaining a lot of weight. The nurse should next:

☐ **1.** Schedule daily family therapy sessions.
☐ **2.** Enroll client in a coping skills group.
☐ **3.** Work with the client to limit her purging.
☐ **4.** Have client take lorazepam (Ativan) 1 mg as needed whenever she feels the urge to binge.

38. During the initial interview, a client with a compulsive eating disorder remarks, "I can't stand myself and the way I look." Which of the following

statements by the nurse is **most** therapeutic?

☐ **1.** “Everyone who has the same problem feels like you do.”
☐ **2.** “I don't think you look bad at all.”
☐ **3.** “Don't worry, you'll soon be back in shape.”
“Tell me more about your feelings.”

39. A community health nurse working with a group of fifth-grade girls is planning a primary prevention to help the girls avoid developing eating disorders during their teen years. The nurse should focus on which of the following?

☐ **1.** Working with the school nurse to closely monitor the girls' weight during middle school.
☐ **2.** Limiting the girls' access to media images of very thin models and celebrities.
☐ **3.** Telling the girls' parents to monitor their daughter's weight and media access.
☐ **4.** Helping the girls accept and appreciate their bodies and feel good about themselves.

Children and Adolescents With Behavior Problems

40. A 17-year-old client who has been taking an antidepressant for 6 weeks has returned to the clinic for a medication check. When the nurse talks with the client and her mother, the mother reports that she has to remind the client to take her antidepressant every day. The client says, “Yeah, I'm pretty bad about remembering to take my meds, but I never miss a dose because Mom always bugs me about taking it.” Which of the following responses would be effective for the nurse to make to the client?

☐ **1.** “It's a good thing your mom takes care of you by reminding you to take your meds.”

“It seems there are some difficulties with being responsible for your medications that we need to address.”

☐ **3.** “You'll never be able to handle your medication administration at college next year if you're so dependent on her.”

☐ **4.** “I'm surprised your mother allows you to be so irresponsible.”

41. The school nurse assesses a 10-year-old girl who excessively cleans and categorizes. Her parents report that she has always been orderly, but since her brother died of cancer 6 months ago, her cleaning and categorizing have escalated. In school, she reads instead of playing with other children. These behaviors are now interfering with homework and leisure activities. To bolster her self-esteem, the nurse should encourage the child to:

☐ **1.** Be a library helper.

☐ **2.** Organize a party for the class.

☐ **3.** Be in charge of a group project with four peers.

☐ **4.** Be captain of the kickball team.

42. A 13-year-old junior high school student has come to the school nurse, stating that her father has physically abused her for 3 years. Initially, the client accepted the abuse, thinking it was because her father had been laid off, but the abuse continued after he got a job 4 months ago. She fears that her mother will not believe her and her father will reject her if they discover she has revealed the abuse. The nurse should **first:**

☐ **1.** Inform the mother in a face-to-face meeting without the girl present.

☐ **2.** Call the father, confront him, and then call the police to have him arrested.

☐ **3.** Meet with both parents together. Include the daughter in the meeting so she can speak for herself.
☐ **4.** Report the alleged abuse to Child Protective Services (Ministry of Children and Family) that day, and then provide for the child's safety.

43. A 15-year-old is a heavy user of marijuana and alcohol. When the nurse confronts the client about his drug and alcohol use, he admits previous heavy use in order to feel more comfortable around peers and achieve social acceptance. He says he has been trying to stay clean since his parents found out and had him seek treatment. When the nurse develops a plan of care with the client, what should be the highest priority to help him maintain sobriety?
☐ **1.** Peer recognition that does not involve substance use.
☐ **2.** Support and guidance from his parents.
☐ **3.** A strict no-drug policy at his high school.
☐ **4.** The threat of legal charges if caught drinking or smoking marijuana.

44. A 17-year-old is admitted to a psychiatric day treatment program due to severe lower back pain since her mother's death 3 years ago. Medical examinations have not discovered a physical cause for her pain. She cares for her four younger siblings after school and on weekends because of her father's long work hours. Which predischarge statement indicates that treatment for her condition has been successful?
☐ **1.** “I understand now why my father spends so much time away from home.”
“My back pain is worse on weekends with more chores and homework.”
☐ **3.** “I don't want to talk about my family. It's my back that is hurting.”
☐ **4.** “I just need more rest and relaxation and then my back will feel fine.”

45. When collaborating with the health care provider to develop the plan of care for a child diagnosed with attention deficit hyperactivity disorder (ADHD), the treatment plan will likely include which of the following?
☐ **1.** Antianxiety medications, such as buspirone (BuSpar), and homeschooling.
☐ **2.** Antidepressant medications, such as imipramine (Tofranil), and family therapy.
☐ **3.** Anticonvulsant medications, such as carbamazepine (Tegretol), and monthly blood levels.
☐ **4.** Psychostimulant medications, such as methylphenidate (Ritalin), and behavior modification.

46. The nurse meets with the mother of a child diagnosed with attention deficit hyperactivity disorder. The mother states, “I feel so guilty that he has this disease, like I did something wrong. I feel like I need to be with him constantly

in order for him to get better. But still sometimes I feel like I'm going to lose control and hurt him." The nurse should suggest which of the following to the mother?

☐ **1.** Arranging for respite care to watch her child and give herself a regular break.
☐ **2.** Taking a job to allow herself to feel some success because her child won't ever improve.
☐ **3.** Arranging to have coffee with friends daily as a way to begin a support group.
☐ **4.** Considering foster care if she feels that she can't handle her child's problems.

47. The nurse is with the parents of a 16-year-old boy who recently attempted suicide. The nurse cautions the parents to be especially alert for which of the following in their son?

☐ **1.** Expression of a desire to date.
☐ **2.** Decision to try out for an extracurricular activity.
☐ **3.** Giving away valued personal items.
☐ **4.** Desire to spend more time with friends.

48. A 19-year-old has struggled academically throughout high school and realizes during her last semester in school that she is not going to graduate with her class, which will delay her admission to college. In the past, she has intermittently used drugs and alcohol to deal with her anxiety, but now her involvement with substances escalates to daily use. In what order of priority from first to last should the school nurse, who has become aware of the problem, take the following actions?

1. Refer her to the school authorities to address her academic issues so she can graduate next semester.

2. Refer her to a program at the local community college to improve the client's readiness for college and decrease her anxiety.

3. Refer her to an outpatient program that treats clients with chemical dependency issues.

4. Refer her to a psychiatric clinic so she can get an appropriate diagnosis

and medication for her anxiety.

49. A mother states to the nurse in her primary care provider's office that she is frustrated regarding her 7-year-old son's nightly enuresis for the past 3 years. She says she has limited his evening fluids, eliminated all caffeine and soft drinks from his diet, and has had him wash his own sheets, but he still wets the bed almost every night. Her husband has told her he was a bed wetter as a child. He thinks the son will "get over it." The mother is worried that it could negatively affect the son's peer relationships as he grows older. Which of the following actions should the nurse take?

☐ **1.** Tell the mother her husband is correct and she should be patient since her husband's enuresis stopped without intervention.

☐ **2.** Suggest asking the primary care provider about medication treatment to deal with the enuresis.

☐ **3.** Discuss a behavioral treatment plan for the child focusing on the improvement of his social skills.

☐ **4.** Suggest the mother ask the primary care provider about hospitalization for a complete renal workup since the enuresis has gone on a long time.

50. A parent of a 7-year-old diagnosed with attention deficit hyperactivity disorder (ADHD) since he was 5 years old is talking to the school nurse about her concerns about the son's physical condition. The parent states that his medication, Concerta (methylphenidate extended release), controls his symptoms well but is causing him to lose weight. It is difficult to get him up and ready for school in the morning unless he is given the medication as soon as he awakens. Then he does not eat breakfast or very much of his lunch at school. He eats dinner, but only an average amount of food. He has lost 3 lb (1.4 kg) in the last 2 weeks. Which of the following should the nurse suggest the parent do **first**?

☐ **1.** Have the child eat a breakfast bar, banana, and a glass of milk at his bedside at the same time he takes his Concerta every morning.

☐ **2.** Monitor the child's weight closely for a month since he is likely to stop losing weight when the school year ends in 2 weeks.

☐ **3.** Suggest a change of medication to a nonstimulant drug that will treat his ADHD without causing the appetite decrease.
☐ **4.** Suggest that the parent supplement the child's dinner with a high-protein drink or other food that will increase his caloric intake.

51. An adolescent is brought to the Emergency Department (ED) after accidentally taking an overdose of heroin (the strength of the heroin he got was greater than the heroin he had been taking). The adolescent is semiconscious, unable to respond appropriately to questions, slurs his words, has constricted pupils, and vital signs of blood pressure 60/50, pulse 50, and respirations 8. Narcan (nalaxone acetate) is administered to temporarily reverse the effects of the heroin. Which of the following would **first** indicate that the Narcan administration had been effective?
☐ **1.** The client's blood opiate level drops to a nontoxic level.
☐ **2.** The client becomes talkative and physically active.
☐ **3.** The client's memory and attention become normal.
☐ **4.** The client's respirations improve to 12/min.

52. Assessment of suicidal risk in children and adolescents requires the nurse to know which of the following?
☐ **1.** Children rarely commit suicide unless one of their parents has already committed suicide, especially in the past year.
☐ **2.** The risk of suicide increases during adolescence, with those who have recently suffered a loss, abuse, or family discord being most at risk.
☐ **3.** Children do have a suicidal risk that coincides with some significant event such as a recent gun purchase in the family.
☐ **4.** Adolescents typically don't choose suicide unless they live in certain geographical regions of the United States and Canada.

53. A child with Asperger's disorder is being referred to the mental health clinic along with his parents. To provide the best care for this family, the nurse makes a care plan based on the fact that this disorder differs from autism in which of the following areas?
☐ **1.** Asperger's disorder, commonly diagnosed earlier than autism, is associated with fewer major problems in interpersonal interactions.
☐ **2.** In Asperger's disorder, behavior commonly is similar to that of other children with autism but without the problems with school.
☐ **3.** Asperger's disorder is recognized later than autism, and interpersonal interaction problems typically become more apparent when the child begins school.
☐ **4.** There are significant problems with language development, as with

autism, but there are no delays or difficulties with motor development.

54. The mother of a 14-year-old girl who is diagnosed with oppositional defiant disorder tells the nurse that she has read extensively on this disorder and does not believe the diagnosis is correct for her daughter. Which of the following responses by the nurse is appropriate?

☐ **1.** "It sounds like you are very interested in your daughter. Let's focus on what is best for her."

"Tell me what you have found in your reading that is leading you to that conclusion."

☐ **3.** "Your doctor has had many years of education and experience, so you can believe he's right."

☐ **4.** "That doesn't matter now because we just need to help her get better."

55. The parents of a preschool child diagnosed with autism must take their child on a plane flight and are concerned about how they can make the experience less stressful for her and their fellow travelers. The nurse in their psychiatrist's office suggests a dry run to the airport in which they simulate going through security and boarding a plane. In addition, the nurse suggests taking items to help the child be calm during the flight. In what order of priority from first to last should the parents employ the items listed below?

1. A DVD player with headphones and favorite games, cartoons, and child films.
2. A favorite stuffed toy animal or other soft toy.
3. A favorite nonelectronic game.
4. Medication that can be given as needed to calm the child.

56. A young school-age girl whose mother and aunt have been diagnosed as having bipolar disorder and whose father is diagnosed with depression is brought to the child psychiatrist's office by her father who has custody since the parents divorced. The father has brought the child to the office because of problems with behavior and attention in school and inability to sleep at night. The child says, “My brain doesn't turn off at night.” The psychiatrist diagnoses the child as experiencing attention deficit hyperactivity disorder (ADHD) with a possibility of bipolar disorder as well as the ADHD. What should the office nurse say to the father to explain what the psychiatrist said? Select all that apply.

“The psychiatrist diagnosed your child as having ADHD because of her attention and behavior problems at school.”

“ADHD involves difficulty with attention, impulse control, and hyperactivity at school, home, or in both settings.”

☐ **3.** “The psychiatrist does not know how to diagnose your child's illness since she has symptoms of both bipolar disorder and ADHD.”

☐ **4.** “The child's description of her inability to sleep is irrelevant to diagnosing her condition since she stays up late.”

“The psychiatrist is considering a bipolar diagnosis because of your child's family history of bipolar disorder and her sleep issues.”

57. At the admission interview, the father of a 4-year-old boy with attention deficit hyperactivity disorder (ADHD) says to the nurse, “I know that my wife or I must have caused this disease.” Which of the following is the nurse's best response?

“ADHD is more common within families, but there is no evidence that problems with parenting cause this disorder.”

☐ **2.** “What do you think you might have done that could have led to causing this disorder to develop in your son?”

☐ **3.** “Many parents feel this way, but I doubt there is anything that you did that caused ADHD to develop in your child.”

☐ **4.** “Let's not focus on the cause but rather on what needs to be done to help your son get better. I know that you and your wife are very interested in helping him to improve his behavior.”

58. A member of a nurse-led group for depressed adolescents tells the group that she is not coming back because she is taking medication and no longer needs to talk about her problems. Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “I'm glad that you are taking your medication, but how can we know that you will continue to take it? After all, you haven't been on it for very long

and you might decide to stop taking it."

☐ **2.** "I think that it is important to let everyone respond to what you said, so let's go around the group and let everyone give their thoughts about what you have decided."

"The purpose of the group is to provide each of you with a place to discuss the problems of being a teenager with depression with others who also are experiencing a similar situation."

☐ **4.** "You don't have to stay in the group if you don't want to, but if you choose to leave, then you won't be able to change your mind later and return to the group."

59. When assessing a 17-year-old male client with depression for suicide risk, which of the following questions is best?

☐ **1.** "What movies about death have you watched lately?"

☐ **2.** "Can you tell me what you think about suicide?"

☐ **3.** "Has anyone in your family ever committed suicide?"

"Are you thinking about killing yourself?"

60. A teacher is talking to the school nurse about a child in her classroom who has a tic disorder. The teacher mentions that the boy frequently trips other children although no one has ever been hurt. The teacher then further states that she ignores him when that happens because it is part of his disorder. The nurse should tell the teacher:

"Tripping other children is not a tic, so you can respond to that as you would in any other child."

☐ **2.** "I can't believe that you actually allow him to get away with that!"

☐ **3.** "I think that is the best choice unless some parents of the other children start to protest about it."

☐ **4.** "If no one else is getting hurt, then it seems harmless and might prevent the development of a worse behavior."

61. A 15-year-old boy being successfully treated for Tourette's syndrome tells the nurse, "I'm not going to take this medication anymore. Anyone who is really my friend will accept me as I am, tics and all!" The nurse should tell the client:

☐ **1.** "You and your family came to the clinic for treatment, so you can terminate it whenever you wish."

☐ **2.** "Won't your lack of medication cause more tics and make you be less attractive to girls?"

"Let's talk about what brought you into treatment and why you now want to stop taking medication."

☐ **4.** “I think that is a very unwise decision, but you're entitled to do whatever you wish.”

62. The nurse leading a group session for parents of children diagnosed with oppositional defiant disorder. The nurse should give which of the following recommendations for discipline?

☐ **1.** Avoid limiting the child's use of the television and computer for punishment.

☐ **2.** Be consistent with discipline while assisting with ways for the child to more positively express anger and frustration.

☐ **3.** Use primarily positive reinforcement for good behavior while ignoring any demonstrated bad behavior.

☐ **4.** Use time-out as the primary means of punishment for the child regardless of what the child has done.

63. A 15-year-old girl is sent to the school nurse with dizziness and nausea. While assessing the girl, who denies any health problems, the nurse smells alcohol on her breath. Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “Don't tell me that you have been drinking alcohol before you came to school this morning!”

☐ **2.** “Why don't you tell me the real reason that you are feeling sick this morning?”

“Tell me everything that you have had to eat and drink yesterday and today.”

☐ **4.** “I know that high school is stressful, but drinking alcohol is not the best way to handle it.”

64. Parents of a 7-year-old child newly diagnosed with attention deficit hyperactivity disorder (ADHD) ask the nurse whether their son will always have to take medication for this condition. The nurse should tell the parents:

☐ **1.** “Yes, almost everyone with this disorder has to continue taking medication forever.”

“Between one-third and one-half of children experiencing ADHD and taking medication will need to continue to take medication as adults.”

☐ **3.** “Most children with this disorder do not need to continue taking medications as adults.”

☐ **4.** “There is just a small percentage of adults with ADHD who can manage without medications.”

65. Which of the following should the nurse include in the teaching plan for the parents of a child who is receiving methylphenidate (Ritalin)?

☐ **1.** Giving the medication at the same time every evening.

☐ **2.** Having the child take two doses at the same time if the last dose was missed.
☐ **3.** Giving the single-dose form of the medication early in the day.
☐ **4.** Allowing concurrent use of any over-the-counter medications with this drug.

66. An 8-year-old child was recently hospitalized at a child psychiatric unit for inattention and acting out behavior at school and home. His psychiatrist prescribed the methylphenidate/ritalin patch to control his attention deficit hyperactivity disorder symptoms, and inpatient unit staff worked with him on behavioral control measures. The office nurse discovers at his first visit after his discharge from the hospital that the boy has been taking off his patch during the day, which is causing problems at school and at home. In which order of priority from first to last should the nurse take the following actions?

1. Explain to the family, in terms the child can understand, the benefits of his medication in dealing with school and home problems he is experiencing.

2. Explore the parents' attitudes about medication administration in general and their child's medication in particular.

3. Explore the child's reasons for removing the patch during the day rather than at the end of the day.

4. Have the psychiatrist discuss with the child and parents a trial of a different medication.

67. A 7-year-old client is diagnosed with conduct disorder. After admission,

the nurse identifies his problematic behaviors as cruelty to animals, stealing, truancy, aggression with peers, lying, and explosive angry outbursts resulting in destruction of property. The nurse is now talking with the client about his behavioral contract, which should include which crucial components? Select all that apply.

☐ **1.** Taking prescribed medications.
☐ **2.** Acceptable methods for expressing anger.
☐ **3.** Consequences for unacceptable behaviors.
☐ **4.** Rules for interacting with staff and other clients.
☐ **5.** Personal possessions allowed on the unit.

68. The nurse is meeting weekly with an adolescent recently diagnosed with depression to monitor progress with therapy and antidepressant medication. The nurse should be **most** concerned when the client reports which of the following?

☐ **1.** An acquaintance hung herself 2 days ago.
☐ **2.** She is experiencing intermittent headaches as a side effect of taking the antidepressant.
☐ **3.** She received a low score on her last history test.
☐ **4.** Her younger brother has been starting fights with her for the last week.

The Child and Adolescent with Adjustment Disorders

69. A 19-year-old male is seriously ill with cystic fibrosis (CF), which he has had since infancy. He is frequently hospitalized for lung infections and is in need of a lung transplant. However, he has a rare blood type that complicates the process of obtaining a donor organ. He has also been diagnosed with bipolar disorder and treated successfully since midadolescence with medication and therapy. How should the nurse on the unit on which he is hospitalized for pneumonia interpret his request for a chaplain to help him make plans for a funeral and donation of his body to science after death?

☐ **1.** It is a signal of the depressive side of his bipolar disorder, and he should be checked for suicidal thoughts/plans.
☐ **2.** It is a signal of an exacerbation of the client's CF and warrants further assessment by his lung specialist.
☐ **3.** It is a signal of the client's awareness he is likely to have a shortened life span and should be supported by unit staff.
☐ **4.** It is a signal of delirium as a result of the many medications he is taking and requires further assessment by the pharmacist or primary care provider.

70. A 6-year-old boy has experienced the death of his mother in the last 3 months. He and his father are involved in a grief support program that has sessions for all ages. A nurse is educating the parents about the normal grief reactions of children to help them distinguish normal behavior from behavior that is unusual and possibly indicative of depression or other psychological issues. Which of the following represents normal grief behavior for this young child after the death of his mother? Select all that apply.

☐ **1.** Talking to his mother as if she were present in the room.
☐ **2.** Crying followed in a few minutes by laughing.
☐ **3.** Playing with a rope, saying he is going to be with his mother.
☐ **4.** Yelling and being angry at his mother for leaving him.
☐ **5.** Playing with a friend right after saying he misses his mother.

71. When counseling a 5-year-old girl who recently suffered the loss of her mother, which of the following statements reflects the typical understanding about death at this age?

“My mommy died last week, but I'm going to see her again.”

☐ **2.** “My daddy said mommy went to heaven, and I'm glad Jesus took her there.”

☐ **3.** “My dog died and now we got another one.”

☐ **4.** “I think Mommy went to heaven and I'll get to see her someday when I die.”

72. A shy 12-year-old girl who must change school systems just before she begins junior high school begins cutting her arms to relieve the stress that she feels about leaving long-standing friends, having to develop new friendships, and meeting high academic standards in her new school. After she has been cutting for a few weeks, her parent discovers the injuries and takes her to a psychiatrist who prescribes a therapeutic group at the local mental health center and medication to help decrease her anxiety. The nurse who is leading the group would determine that the girl had made appropriate progress toward recovery when which of the following occurred? Select all that apply.

☐ **1.** The girl indicated that she had joined three clubs at school and agreed to be an officer in one of them.

☐ **2.** The girl says she has developed a friendship with a girl in her class and one in her therapy group.

☐ **3.** The girl wears short-sleeved and/or sleeveless tops when the weather is warm.

☐ **4.** The girl's grades are good, and her hours of study are not excessive.

☐ **5.** The girl begins saying she must study hard so she can get into a good university.

Managing Care Quality and Safety

73. Which of the following children should the nurse identify as being more at risk for an episode of major depression?

☐ **1.** A 16-year-old male, who has been struggling in school, making only Cs and Ds.

☐ **2.** A 13-year-old female, who was upset over not being chosen as a cheerleader.

☐ **3.** A 10-year-old male, who has never liked school and has few friends.

☐ **4.** A 14-year-old, who recently moved to a new school after her parents' divorce.

74. A staff nurse on the mental health unit tells the nurse manager that kids with conduct disorders might as well be jailed because they all end up as adults with antisocial personality disorder anyway. What is the best reply by the nurse manager?

☐ **1.** “You really sound burned out. Do you have a vacation coming up soon?”

☐ **2.** “These children are more likely to have problems with depression and anxiety disorder as adults.”

“You sound really frustrated. Let's talk about the meaning of their behavior.”

☐ **4.** “My experience hasn't been that negative. Let's see what the other staff members think; maybe I'm wrong.”

75. Which of the following children should the nurse assess as demonstrating behaviors that need further evaluation?

☐ **1.** Joey, age 2, who refuses to be toilet-trained and talks to himself.

☐ **2.** Adrienne, age 6, who sucks her thumb when tired and has never spent the night with a friend.

☐ **3.** Curt, age 10, who frequently tells his mother that he is going to run away whenever they argue.

☐ **4.** Stephen, age 2, who is indifferent to other children and adults and is mute.

76. A nurse has been caring for a 12-year-old adolescent client in a residential facility. The child has been through a series of foster placements since infancy with no success in any placement until the age of 7 when placed with a middle-aged single woman. The client thrived there until the woman was killed in a car accident. The client attempted suicide after her foster mother died in response to the loss and the child was placed in the residential facility. The nurse has become close to this client and wants to help her address her issues and

move on with her life. Which of the following comments to the manager demonstrates that the nurse understands the client's issues and is able to respond appropriately to the client's needs?

“It's difficult for her to love and trust again after her losses. In this facility, she can learn to deal with her loss in a less emotionally charged environment than a foster home.”

☐ **2.** “She just needs someone who will love her and give her the things she has missed out on in life. An adoptive family needs to be found for her as soon as possible.”

☐ **3.** “I'm not sure she is going to be able to get past all the loss and rejection she's experienced. I don't think adoption will ever be a viable option for her.”

☐ **4.** “I know her well and am familiar with her issues. I think the best chance for success for her would be if she was adopted into my family.”

77. Which of the following adolescents would the nurse determine needs further evaluation?

☐ **1.** A young adolescent girl whose mood changes when upset with her parents, though she has never been in trouble in school or the community.

☐ **2.** A young adolescent boy who coughs for 5 minutes after trying his first marijuana cigarette and declares he does not want to do it again.

☐ **3.** A young adolescent boy who restricts his food and fluid intake in order to be able to box in a lower weight class.

☐ **4.** A young adolescent girl who reads “dark” novels and questions why God allows innocent people to be harmed.

78. A new client has just been admitted to an adolescent psychiatric inpatient unit. The charge nurse and an aide are discussing the client's needs. The aide says, “She is just showing off to try and get our sympathy. There is no need for her to cut herself. Why would adolescents want to do such a thing to themselves?” Which of the following responses by the charge nurse would **most help** the aide understand the client and her illness?

☐ **1.** “She is not doing the cutting for attention since she always wears clothing that covers up her injuries and further, she is not willing to talk about it.”

“It is hard to see a young person harm herself as she does, but she has serious family issues and does not know better ways to handle them, so we have to help her with that.”

☐ **3.** “You do not understand her problems and do not take them seriously, so you should not be allowed to work with her during her hospitalization.”

☐ **4.** “Perhaps you should transfer to another unit where you are able to have

empathy for the clients.”

Answers, Rationales, and Test-Taking Strategies

The answers and rationales for each question follow below, along with keys ( *) to the client need (CN) and cognitive level (CL) for each question. As you check your answers, use the* ***Content Mastery and Test-Taking Skill Self-Analysis*** *worksheet (tear-out worksheet in back of book) to identify the reason(s) for not answering the questions correctly. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21 and pages 31–32 in Part 1 of this book.*

The Client Experiencing Abuse

1. 2. The safety of the client and her children is the most immediate concern. If there is immediate danger, action must be taken to protect them. The other options can be discussed after the client's safety is assured.

 CN: Psychosocial integrity; CL: Analyze

2. 3. The traditional and rigid gender roles described by the client are examples of role stereotyping. Impermeable boundaries, unbalanced power ratio, and dysfunctional feeling tone are also common in abusive families.

 CN: Safety and infection control; CL: Analyze

3. 4. The client's safety, including the need to stay alive, is crucial. Therefore, helping the client develop a safety plan is most important to include in the plan of care to ensure the client's safety. Being empathetic, teaching about abuse, and explaining the person's rights are also important after safety is ensured.

 CN: Psychosocial integrity; CL: Synthesize

4. 2, 3, 4, 5. The victim of abuse is usually compliant with the spouse and feels guilt, shame, and some responsibility for the battering. Self-blame, substance abuse, and suicidal thoughts and attempts are possible dysfunctional coping methods used by abuse victims. The victim of abuse is not likely to demonstrate assertiveness.

 CN: Psychosocial integrity; CL: Analyze

5. 2. The nurse needs more information about the client's decision before deciding what intervention is most appropriate. Judgmental responses could

make it difficult for the client to return for treatment should she want to do so. Telling the client that this is a bad decision that she will regret is inappropriate because the nurse is making an assumption. Warning the client that abuse commonly stops when one partner is involved in treatment may be true for some clients. However, until the nurse determines the basis for the client's decision, this type of response is an assumption and therefore inappropriate. Reminding the client about her duty to protect the children would be appropriate if the client had talked about episodes of current abuse by her partner and the fear that her children might be hurt by him.

 CN: Psychosocial integrity; CL: Synthesize

6. 3. The mother's feelings are the priority here. Addressing the mother's feelings and asking for her view of the situation is most important in building a relationship with the family. Ignoring the mother's feelings will hinder the relationship. Defending the school nurse and the school puts the client's mother on the defensive and stifles communication.

 CN: Psychosocial integrity; CL: Synthesize

7. 4. Parental use of nonviolent discipline, the child's talk about what the family is doing and the easing of the parent's negativity toward the school nurse are all signs of progress. Avoidance and wearing clothes inappropriate for the weather implies that the child has something to hide, likely signs of physical abuse.

 CN: Psychosocial integrity; CL: Analyze

8. 4. Ultimately, a victim of a crime needs to move from being a victim to being a survivor. A reasonable sense of safety and security is key to this transition. Getting through the shock and confusion, carrying out home and work routines, and resolving grief over any losses represent steps along the way to becoming a survivor.

 CN: Psychosocial integrity; CL: Synthesize

9. 2. The experience of rape is a crisis. Crisis intervention services, especially with a rape crisis nurse, are essential to help the client begin dealing with the aftermath of a rape. Legal assistance may be recommended if the client decides to report the rape and only after crisis intervention services have been provided. A rape support group can be helpful later in the recovery process. Medications for sleep disturbance, especially benzodiazepines, should be avoided if possible. Benzodiazepines are potentially addictive and can be used in suicide attempts, especially when consumed with alcohol.

CN: Psychosocial integrity; CL: Synthesize

10. 3. Guilt and self-blame are common feelings that need to be addressed directly and frequently. The client needs to be reminded periodically that she did not deserve and did not cause the rape. Continually encouraging the client to report the rape pressures the client and is not helpful. In most cases, resuming sexual relations is a difficult process that is not likely to occur quickly. It is not necessarily true that the rapist will be caught, tried, and jailed. Most rapists are not caught or convicted.

CN: Psychosocial integrity; CL: Apply

11. 4. Use of alcohol reflects unhealthy coping mechanisms. A client's report of needing alcohol to calm down needs to be addressed. Survival is the most important goal during a rape. The client's acknowledging this indicates that she is aware that she made the right choice. Although suicidal thoughts are common, the statement that suicide is an easy escape but the client would be unable to do it indicates low risk. Fantasies of revenge, such as giving the death penalty to all rapists, are natural reactions and are a problem only if the client intends to carry them out directly.

CN: Psychosocial integrity; CL: Evaluate

12. 3. Coercion is the most common strategy used because the child commonly trusts the abuser. Tying the child down usually is not necessary. Typically, the abusive person can control the child by his or her size and weight alone. Bribery usually is not necessary because the child wants love and affection from the abusive person, not money. Young children are not capable of giving consent for sex before they develop an adult concept of what sex is.

CN: Psychosocial integrity; CL: Apply

13. 2. Truancy and running away are common symptoms for young children and adolescents. The stress of the abuse interferes with school success, leading to the avoidance of school. Running away is an effort to escape the abuse and/or lack of support at home. Rather than an inability to play or a lack of play, play is likely to be aggressive with sexual overtones. Children tend to act out anger rather than control it. Head banging is a behavior typically seen with very young children who are abused.

CN: Psychosocial integrity; CL: Analyze

14. 3. Dealing with the physical pain associated with mutilation is viewed as easier than dealing with the intense anger and emotional pain. The client fears an aggressive outburst when anger and emotional pain increase. Self-mutilation

seems easier and safer. Additionally, self-mutilation may occur if the client feels unreal or numb or is dissociating. Here, the mutilation proves to the client that he or she is alive and capable of feeling. The client may want to be less sexually attractive, but this aspect usually is not related to self-mutilation. Binging and purging is commonly done in addition to, not instead of, self-mutilation. Although a few clients report an occasional high with self-mutilation, usually the experience is just relief from anger and rage.

 CN: Psychosocial integrity; CL: Analyze

15. 1. The dolls and toys in a play therapy room are useful props to help the child remember situations and re-experience the feelings, acting out the experience with the toys rather than putting the feelings into words. Role-playing without props commonly is more difficult for a child. Although drawing itself can be therapeutic, having the abuser see the pictures is usually threatening for the child. Reporting abuse to authorities is mandatory, but doesn't help the child express feelings.

 CN: Psychosocial integrity; CL: Synthesize

16. 2, 3, 4, 5. Using a foam bat while symbolically confronting the abuser, keeping a journal of memories and feelings, and writing letters about the abuse but not sending them are appropriate strategies because they allow anger to be expressed safely. Directly confronting the abuser is likely to result in further harm because the abusers commonly deny the abuse, rationalize about it, or blame the victim.

 CN: Psychosocial integrity; CL: Synthesize

17. 4. The safety of other children is a primary concern. It is critical to know whether other children are at risk for being sexually abused by the same perpetrator. Asking about other forms of abuse, how long the abuse went on, and if the victim did not remember the abuse are important questions after the safety of other children is determined.

 CN: Psychosocial integrity; CL: Synthesize

18. 4. From documented cases of child abuse, a profile has emerged of a high-risk parent as a person who is isolated, impulsive, impatient, and single with low self-esteem, a history of substance abuse, a lack of knowledge about a child's normal growth and development, and multiple life stressors. Just because a parent comes from a large family, there is no increase in the incidence of the parent abusing their own children unless they possess the other risk factors.

 CN: Psychosocial integrity; CL: Apply

19. 4. Parents of an abused child have difficulty controlling their aggressive behaviors. They may blame the child or others for the injury, may not ask questions about treatment, and may not know developmental information.

 CN: Psychosocial integrity; CL: Analyze

20. 1. It is not normal for a preschooler to be totally passive during a painful procedure. Typically, a preschooler reacts to a painful procedure by crying or pulling away because of the fear of pain. However, an abused child may become “immune” to pain and may find that crying can bring on more pain. The child needs to learn that appropriate emotional expression is acceptable. Telling the child that it really didn't hurt is inappropriate because it is untrue. Telling the child that nurses are mean does not build a trusting relationship. Praising the child will reinforce the child's response not to cry, even though it is acceptable to do so.

 CN: Psychosocial integrity; CL: Synthesize

21. 3. A 3-year-old child has limited verbal skills and should not be asked to describe an event, explain a picture, or respond verbally or nonverbally to questions. More appropriately, the child can act out an event using dolls. The child is likely to be too fearful to name the perpetrator or will not be able to do so.

 CN: Psychosocial integrity; CL: Synthesize

22. 3. An almost universal finding in descriptions of abused children is underdevelopment for age. This may be reflected in small physical size or in poor psychosocial development. The child should be evaluated further until a plausible diagnosis can be established. A child who appears happy when personnel work with him is exhibiting normal behavior. Children who are abused often are suspicious of others, especially adults. A child who plays alongside others is exhibiting normal behavior, that of parallel play. A child who sucks his thumb contentedly is also exhibiting normal behavior.

 CN: Psychosocial integrity; CL: Analyze

23. 3. Parents who are abusive often suffer from low self-esteem, commonly because of the way they were parented, including not being able to develop trust in caretakers and not being encouraged or offered emotional support by parents. Therefore, the nurse works to bolster the parents' self-esteem. This can be achieved by praising the parents for appropriate parenting. Employment and socioeconomic status are not indicators of abusive parents. Abusive parents usually are attached to their children and do not want to give them up to foster

care. Parents who are abusive love their children and feel close to them emotionally.

CN: Psychosocial integrity; CL: Analyze

24.

1. Interview the teen about how he is handling the divorce, any bullying he may be experiencing, and his current grades.

4. Ask the boy about self-injury, depression, and suicidality in connection with the scars on his wrists.

2. Interview the mother further about the child's early childhood and any potential antecedents to his current behavior.

3. Interview the father about his awareness of his son's behavior and perspective concerning it as well as the relationship between him and his son.

The nurse should talk to the boy directly about how he is dealing with the stresses in his life, but he may not be forthcoming if the nurse approaches the self-injury first. Once the nurse has established rapport and learned about the client's view of his situation, it will be more likely that the client will be honest about his self-injury and any depression or suicidal thoughts or plans he may have. Since the mother called the nurse with her concerns about her son, a further interview with the mother would be the next step to take. Because there is conflict in the home, it would be necessary to also interview the father for his perspective of the situation. If he is not aware of his son's self-injury, he needs to be informed of it.

CN: Safety and infection control; CL: Create;

25. 2, 3, 4, 5. Education of all students in the school about cyberbullying is appropriate and possible as programs exist to educate students in many communities. That education and his therapy should enable Joe to eventually return to using the Internet safely and to feel more confidence interacting with classmates. Disciplining of the student who posted Joe's picture by school authorities is appropriate and can be helpful in reducing further incidents of

cyberbullying. It is unrealistic to think that all those who forwarded the message could be identified, much less taken off Facebook.

 CN: Psychosocial integrity; CL: Evaluate

The Adolescent With Eating Disorders

26. 1, 2, 4. In hospital settings, clients are not allowed to know their weight at the time they are being weighed to decrease obsessing about weight gain. They must also eat and rest in staff view and cannot use the bathroom for a period to prevent discarding food or vomiting ingested food (purging). The rest prevents the client from exercising off the calories they just consumed. Barring clients from ever talking about food or attending groups until they have gained weight diminishes the therapeutic value of the inpatient hospital stay.

 CN: Psychosocial integrity; CL: Create

27. 3. In responding to the client, the nurse must be nonjudgmental and matter of fact. Telling her that weight gain is in her favor ignores the client's extreme fear of gaining weight. Putting off the weigh-in for 2 hours allows the client to manipulate the nurse and interferes with the need to weigh the client at the same time each day. Threatening to call the doctor is not likely to build rapport or a working relationship with the client.

 CN: Psychosocial integrity; CL: Synthesize

28. 2. A client with anorexia nervosa commonly has an extreme fear of not being able to control weight. The nurse should address this fear. Explaining the dangers of diet pills or discussing health care provider or family concerns focuses on the effect of the client's weight loss on other people rather than the client. Unless the client is motivated to stop, the client will likely not be successful.

 CN: Psychosocial integrity; CL: Synthesize

29. 4. An intense fear of becoming obese, emaciation, and a disturbed body image all are considered to be characteristic of anorexia nervosa. Near-normal weight is not associated with anorexia. The weight of others is not a primary factor. Concern about dieting is not strong enough language to describe the control of food intake in the individual with anorexia nervosa.

 CN: Psychosocial integrity; CL: Apply

30. 1. Anorexia nervosa occurs most commonly in girls and women, with the age at onset between 12 and 20 years. It begins less commonly after 30 years. Although anorexia occurs in men, the prevalence rate is less than 5% to 10% of

all cases of anorexia.

CN: Psychosocial integrity; CL: Apply

31. 3. Parents commonly describe their child as a model child who is a high achiever and compliant. These adolescents are typically well liked by teachers and peers. It is not typical for behavior problems to be reported. The description about having given the child everything and being repaid is more likely to describe an adolescent who is exhibiting behavior problems.

CN: Psychosocial integrity; CL: Analyze

32. 1. The large carbohydrate intake and significant time in the bathroom are characteristics of bulimia. To address the problem, the client must obtain an evaluation of her physical and psychological status. Suggesting going to a weight loss program or overeating support group frames the problem as strictly a weight issue and ignores the psychological etiology of the problem. Seeing the family's primary health care provider does not address the psychological aspect of the client's illness, and the client must make the appointment herself.

CN: Psychosocial integrity; CL: Apply

33. 1, 2, 3, 4. Because of the large number of calories ingested in a binge and the fact that a purge does not eliminate all calories consumed, the client with bulimia is of more normal weight but still must have a goal of maintaining that weight. Research has shown that selective serotonin reuptake inhibitors are effective in treating bulimia, and the client is usually amenable to taking the medication. The client with an eating disorder (bulimia and anorexia) has negative self-concepts that fuel her disordered eating, and attaining a positive self-concept is an appropriate goal. The nurse should work with the client with bulimia to help her recognize her eating as disordered. That recognition can make the client more amenable to treatment. It is not realistic to establish a goal that the client with bulimia will never have the desire to purge again.

CN: Psychosocial integrity; CL: Create

34. 3. A successful outcome for a bulimic client is to avoid using the eating disorder as a coping measure when dealing with stress. Being able to attend college in another state, eat at home, and eat out without binging and purging are important goals, but do not address the primary problem of stress management and its connection to eating.

CN: Psychosocial integrity; CL: Create

35. 3. By telling the mother that the coach is a nurse and relaying the behaviors observed, the nurse gives the mother a chance to recognize the

expertise of the coach and introduces the possibility of an eating disorder. Thanking the mother and complimenting the player does not begin to approach the topic. Telling the mother that the nurse has some very bad news is negative and dramatic. Additionally, although the observed behaviors suggest an eating disorder, it would be inappropriate for the nurse to medically diagnose the daughter. Although the daughter may indeed be very sick and need to see a therapist, the nurse should relate the information in a matter-of-fact, unemotional way.

 CN: Psychosocial integrity; CL: Synthesize

36. 3. Encouraging the client to talk about why she is here and her feelings may reveal more information about what led her to come to the group and what led to her diagnosis. It also provides the nurse with valuable information needed to develop an appropriate plan of care. The comment that the client sounds angry presumes what the client is feeling and focuses the talk on her husband. The focus should be on the client, not the husband. Telling the client that she will like coming to group imposes the nurse's view onto the client. The statement also focuses on having fun in the group instead of stressing the therapeutic value. Having the client tell the nurse something about the cause of her bulimia ignores the client's original statement. In addition, it requires the client to have insight into the cause of her disease, which may not be possible at this point. Also, it may be too early in the relationship to discuss this disorder.

 CN: Psychosocial integrity; CL: Synthesize

37. 2. Because the client eats excessively when upset, the best treatment would be a group to help her learn alternative coping skills. Trying to limit purging without controlling binging would result in weight gain and likely increase the client's purging. Daily family therapy sessions are not realistic. Taking lorazepam whenever she feels she needs to binge may temporarily calm the client, but does not address the cause of the binging and purging and further, will lead to drug dependence with long-term use.

 CN: Psychosocial integrity; CL: Synthesize

38. 4. The nurse needs to explore more about the client's feelings to assess what underlies the eating disorder. The nurse also needs to evaluate the client's suicide risk. The other statements are not therapeutic because they minimize the client's feelings.

 CN: Psychosocial integrity; CL: Synthesize

39. 4. The goal of a primary prevention program for eating disorders is for

the girls to have positive feelings about themselves and their bodies. Monitoring of weight by parents and/or school nurses might note eating disorders early, particularly anorexia, but will not address the cause of the disorder. Limiting the girls' access to media would be impossible and does not prevent distress with one's body image.

 CN: Psychosocial integrity; CL: Synthesize

Children and Adolescents With Behavior Problems

40. 2. The client and mother need to address the issue of responsibility for medication administration. Reinforcing the mother's overinvolvement in medication taking or making negative comments about the client and mother t are unlikely to engage them in problem solving about the matter.

 CN: Psychosocial integrity; CL: Synthesize

41. 1. This child is demonstrating signs of anxiety and withdrawal. Being a library helper enables the client to use an interest (reading) when interacting with others and gaining pride in helping others. Most interaction will be one-to-one and with adults, which is likely to be more comfortable for her in her state of anxiety. Organizing a class party, a group project with her peers, and a kickball team involve multiple peer interactions, which are likely to be difficult for her at this time. Also, there is no mention of the child liking sports, so kickball would not be an appropriate activity.

 CN: Psychosocial integrity; CL: Synthesize

42. 4. All suspected child abuse must be reported, but this child's age and ability to describe the abuse make this allegation particularly strong. Because parental reaction to her allegation is not predictable, the nurse must ensure the child's safety. The nurse should not discuss the situation with the client or the parents. The nurse must refer this case to Child Protective Services (the Ministry of Children and Family).

 CN: Management of care; CL: Synthesize

43. 1. Peer acceptance and recognition is a very powerful force in the lives of adolescents, leading to positive or negative behavior depending on the child's peers. While the influence of parents remains strong, peer acceptance combined with the adolescent's desire for independence can lead to disobeying the parents. The sanctions provided at school and in the community by law enforcement will support those teens that have other support in their lives, but are generally not sufficient to prevent substance use in adolescents lacking support at home and with peers.

CN: Psychosocial integrity; CL: Create

44. 2. This statement indicates insight into possible emotional causes for her pain. After insight is achieved, the client can make behavior changes to effectively cope with her anxiety-related disorder. Saying that she understands why her father is away so often demonstrates insight into her father's actions rather than her own. Wanting to discuss her pain and not her family indicates denial of any connection between her pain and her stress, which perpetuates her current situation. While rest may help her back, the client's statement does not address psychological issues related to the back pain.

CN: Psychosocial integrity; CL: Evaluate

45. 4. ADHD is typically managed by psychostimulant medications, such as methylphenidate and pemoline (Cylert), along with behavior modification. Antianxiety medications, such as buspirone, are not appropriate for treating ADHD. Homeschooling commonly is not a possibility because both parents work outside the home. Antidepressants, such as imipramine, are not recommended for use in children. Family therapy may be a part of the treatment. Anticonvulsant medications, such as carbamazepine, are not appropriate for ADHD. Also, carbamazepine levels are obtained weekly early during therapy to avoid toxicity and ascertain therapeutic levels.

CN: Pharmacological and parenteral therapies; CL: Apply

46. 1. Suggesting that the mother arrange for respite care so that she can have a regular break would help to alleviate some of the stress that she feels when she is with her child constantly. The mother also could use family and friends to provide some care, thereby helping with giving her a break. The child may improve, so suggesting that the mother take a job to provide a feeling of success would be inappropriate. Having coffee daily with friends may provide some opportunities for socialization. However, friends may not be able to provide the verbal support that the mother needs. Rather, attending a support group of other parents with children with attention deficit hyperactivity disorder might be helpful. Placing the child in foster care is an extreme measure that may damage the therapeutic relationship with the nurse and dramatically and negatively affect the relationship between the mother and child.

CN: Psychosocial integrity; CL: Synthesize

47. 3. Giving away personal items has consistently been shown to be an indicator of suicide plans in a depressed and suicidal individual. Expression of a desire to date, trying out for an extracurricular activity, or the desire to spend

more time with friends indicates a return of interest in normal adolescent activities.

 CN: Psychosocial integrity; CL: Analyze

48.

4. Refer her to a psychiatric clinic so she can get an appropriate diagnosis and medication for her anxiety.

3. Refer her to an outpatient program that treats clients with chemical dependency issues.

1. Refer her to the school authorities to address her academic issues so she can graduate next semester.

2. Refer her to a program at the local community college to improve the client's readiness for college and decrease her anxiety.

The client's anxiety seems to fuel her substance abuse, so treatment for her anxiety is paramount, followed by treatment for substance abuse. Those two interventions should increase her readiness to profit from academic aid offered by the school. Referral to a community college program would help her get ready for college, which will likely decrease her anxiety.

 CN: Psychosocial integrity; CL: Create

49. 2. The mother's distress and length of time the problem has existed combined with the efforts she has made to address the problem demonstrate that medication treatment should be considered. The absence of any other symptoms make a renal workup unnecessary at this time. It is unlikely that social skills training alone will change his nocturnal enuresis. Just waiting for the behavior to stop is likely to further tax the mother and son.

 CN: Psychosocial integrity; CL: Create

50. 1. Because weight loss is a common side effect of methylphenidate and because the child's symptoms are controlled with the stimulant, the first action should be to increase the child's oral intake before the medication's side effects begin. Weight should be monitored, but since the child has already lost weight, a

remedy is needed as well as monitoring. The weight loss is directly due to the medication's side effects, so the child will continue to lose weight unless an intervention is made whether or not he is enrolled in school or on summer vacation. A high-protein drink could work, but then the child is taking in all his calories in the evening, which is not best nutritionally. A change of medication should be the last resort since methylphenidate is the most effective medication for ADHD and has been successful with this child.

 CN: Pharmacological and parenteral therapies; CL: Analyze

51. 4. Decreased respirations and coma are the two most dangerous effects of heroin overdose, so an increase in respirations after administration of the Narcan demonstrates initial effectiveness of the medication. Changes in cognition and psychomotor activity will take more time to become apparent. The client's blood opioid level may not drop to a nontoxic level for a few days.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

52. 2. Adolescents are more likely than children to attempt or commit suicide. Loss, abuse, and family discord remain significant risk factors. There is no evidence to support that children rarely commit suicide. Additionally, evidence fails to support the belief that children who have lost a parent to suicide will attempt it themselves. Significant events, such as a recent firearm purchase, have not been linked to suicide attempts in children. No geographical region in the United States or Canada is free from adolescent suicide.

 CN: Psychosocial integrity; CL: Apply

53. 3. Asperger's disorder is recognized later than autism, and the interpersonal problems worsen with school attendance. These children usually have restricted and repetitive patterns of behavior. School problems exist as a result of the interaction difficulties and behavior differences. Motor development may be delayed, but language commonly progresses normally.

 CN: Psychosocial integrity; CL: Apply

54. 2. The nurse needs to find out what exactly the mother knows and has read. Reviewing what the mother has found in her reading that is leading her to doubt the diagnosis will help direct the nurse's teaching and clarify any misperceptions or misinformation that the mother may have. The primary health care provider may indeed have many years of education and experience, and the focus should be on the daughter, but the nurse needs to address the mother's concerns at this time.

 CN: Psychosocial integrity; CL: Synthesize

55.

1. A DVD player with headphones and favorite games, cartoons, and child films.

3. A favorite nonelectronic game.

2. A favorite stuffed toy animal or other soft toy.

4. Medication that can be given as needed to calm the child.

Electronic games and stories are favorites of most children, but are particularly enjoyed by children on the autism spectrum. The headphones block out some of the noises that might be upsetting to a child on the autism spectrum. If the child cannot be engaged electronically, a favorite nonelectronic toy would be the next choice. Stuffed animals or other soft toys can soothe a child who is starting to become upset. Medication should be a last resort as it can have a paradoxical effect if it is an antianxiety medication or may cause too much sedation during the flight.

CN: Psychosocial integrity; CL: Create

56. 1, 2, 5. The client's school problems, the presence of first-degree relatives diagnosed with bipolar disorder and depression, and her inability to sleep at night mirror aspects of both ADHD and bipolar disorder, which are difficult to distinguish from each other in children. Psychiatrists are reluctant to diagnose young children as bipolar at this age. She may have only one disorder or the other or both. Further monitoring and her response to medication will differentiate whether she is suffering from one of the disorders or both. Any comments indicating that the psychiatrist does not know what he or she is doing or that the child's perceptions of her illness are not valid will undermine any trust the father and child might be developing in their caregiver and so should be avoided.

CN: Psychosocial integrity; CL: Apply

57. 1. Stating that attention deficit hyperactivity disorder occurs more commonly in families takes the opportunity for teaching while also helping the father realize that he and his wife are not to blame. Parents who are commonly

blamed by society for their child's behavior need help with education. Questioning the father on what he thinks he may have done implies that the parents played some role in this disorder, possibly contributing to the father's guilt. Telling the father that many parents feel this way and that the nurse does not think the parents are at fault is premature at this point. Telling the father that he should focus on what needs to be done, rather than what caused the disorder, minimizes the father's concerns and feelings.

 CN: Psychosocial integrity; CL: Synthesize

58. 3. Focusing on the purpose of the group is the best response. Adolescents are greatly influenced by their peers. Medication alone is not typically the most successful treatment strategy. Questioning whether the client will continue the medication is negative and is not the reason for her to stay in the group. Asking the rest of the group to respond may or may not give the nurse support for the teenager remaining in the group. Groups commonly have rules regarding movement of members in and out of the group, but this does not address the reasons for the client to remain in the group.

 CN: Psychosocial integrity; CL: Synthesize

59. 4. Asking whether the client is thinking about killing himself is the most direct and therefore the best way to assess suicidal risk. Knowing whether the client has watched movies on suicide and death, what the client thinks about suicide, and whether other family members have committed suicide will not tell the nurse whether the client is thinking about committing suicide right now.

 CN: Psychosocial integrity; CL: Analyze

60. 1. The teacher needs to be informed that this behavior is inappropriate. Therefore, educating the teacher and encouraging her to respond to misbehavior consistently is correct. Telling the teacher that the nurse can't believe the teacher lets the child get away with the behavior is demeaning and condescending. Allowing the child to continue the misbehavior is counterproductive to discipline and could create other problems.

 CN: Psychosocial integrity; CL: Synthesize

61. 3. When an adolescent wants to stop treatment with medication, it represents a desire for more control over his/her life as well as a wish to be free of the disorder with which they have been diagnosed. If the caregiver merely acknowledges the client's right to stop treatment or warns of consequences if the client stops medication, he or she abdicates the adult role of health care advisor. Before any action is taken, the nurse should explore the client's reasoning to see

if anything in the medication regimen could be changed to make it more palatable for the client. The client also needs to know that if his current objections cannot be overcome, he can return later to restart his medication.

 CN: Psychosocial integrity; CL: Synthesize

62. 2. Consistent discipline and alternative methods of anger management are two important tools for parents who have a child with oppositional defiant disorder. Consistent discipline sets limits for the child. Helping the child learn more appropriate ways to manage anger assists the child in living within societal expectations. Avoiding restriction of television and computer time for punishment or using time-out as the primary means of punishment has not been suggested as an appropriate management method. Typically, using many strategies is more effective. Ignoring bad behavior could be dangerous and does not reinforce to the child that limits on behavior exist in society.

 CN: Psychosocial integrity; CL: Synthesize

63. 3. Asking the client to report everything that she has had to eat and drink yesterday and today is the least judgmental approach and also provides helpful information. Confronting the client about drinking alcohol or asking the client to admit the real reason for feeling sick can put the girl on the defensive and block further communication. The nurse should avoid putting the client on the defensive to facilitate communication that may eventually enable the nurse to get the truth and identify interventions.

 CN: Psychosocial integrity; CL: Synthesize

64. 2. Studies show that usually one-third to one-half of people diagnosed with ADHD do not need medication as adults.

 CN: Psychosocial integrity; CL: Synthesize

65. 3. The single-dose form of methylphenidate should be taken 10 to 14 hours before bedtime to prevent problems with insomnia, which can occur when the daily or last dose of the medication is taken within 6 hours (for multiple dosing) or 10 to 14 hours (for single dosing) before bedtime. It is recommended that a missed dose be taken as soon as possible; the dose is skipped if it is not remembered until the next dose is due. Any other medication, including over-the-counter medications, should be discussed with the health care provider before use to eliminate the risk of a possible drug interaction.

 CN: Pharmacological and parenteral therapies; CL: Create

66.

3. Explore the child's reasons for removing the patch during the day rather than at the end of the day.

2. Explore the parents' attitudes about medication administration in general and their child's medication in particular.

1. Explain to the family, in terms the child can understand, the benefits of his medication in dealing with school and home problems he is experiencing.

4. Have the psychiatrist discuss with the child and parents a trial of a different medication.

First, the child's reasons for removing the patch need to be explored to determine what needs to be done to solve the problem of inadequate medication administration. Since the child is probably heavily influenced by his parents' attitudes about taking medications, their attitudes need to be addressed next to determine if they openly or subtly oppose the medication or its method of administration. Once the knowledge of the child's and parent's feelings about medication are known, education can be offered to be sure the child understands how the medication can help him cope better in school and home. If the child continues to take off his patch or demonstrates an allergic response to the patch or if it is determined that his parents are not supportive of the patch, discussion of a trial of another medication to treat the child's symptoms should occur.

 CN: Pharmacological and parenteral therapies; CL: Create

67. 1, 2, 3, 4. The crucial elements of a behavioral contract include compliance with the medication regimen if medication is prescribed, appropriate anger management, consequences for unacceptable behaviors, and rules for interactions with others. Personal possessions may be limited by unit rules, but are not part of an individualized behavioral contract.

 CN: Psychosocial integrity; CL: Create

68. 1. While all the occurrences could upset the client in the early stage of treatment, the one involving the most risk to safety is the suicide completion of a peer. Adolescents are susceptible to “copycat” suicides. The fact that she knows the method of suicide of the acquaintance and is at a critical period in treatment,

when her antidepressant may have given her increased energy while still experiencing low self-esteem, can put her at significant risk for suicide.

 CN: Safety and infection control; CL: Analyze

The Child and Adolescent With Adjustment Disorders

69. 3. A client who has endured serious chronic illness (both psychiatric and medical) would be well aware of his shortened lifespan, particularly if he is unable to get a lung transplant. It would not be unusual for him to want to plan ahead, so his wishes would be honored in the event of his death. In the absence of other physical signs, an exacerbation of CF or delirium is not demonstrated. Likewise, his successful bipolar treatment in the absence of any other signs rules depression out as a reason for his behavior. Though it may be difficult for us to think about a young person in terms of dying, the client's consideration of the future is a rational decision.

 CN: Psychosocial integrity; CL: Analyze

70. 1, 2, 4, 5. Young children cannot be sad all the time after a loss, but that does not mean they grieve less. Their moods change more quickly and they often work out their issues through play rather than talking. Because young children do not have a full understanding of death's finality, they may talk to a deceased loved one as if they are present. They also may not understand the circumstances of the death and so may think the loved one left voluntarily and be angry at the deceased for leaving them. Play involving a dangerous object such as a rope, coupled with a stated desire to join the deceased parent, would be cause for alarm as the child could harm himself either purposely or accidentally.

 CN: Psychosocial integrity; CL: Apply

71. 1. Five-year-old children view death as reversible, so talking about seeing her mother again is a normal statement for a child of this age. A child this age would not usually state that she was glad Jesus took her mom but instead might be afraid that Jesus would also take her or her dad. The idea of replacing her mother with a new one, as hinted in the statement that they got another dog after the dog died, has not been supported by studies of grieving children. Stating that mommy went to heaven and that the child will see her someday when the child dies is reflective of more advanced abstract thinking than a 5-year-old would demonstrate.

 CN: Health promotion and maintenance; CL: Analyze

72. 2, 3, 4. The development of friendships and good grades with moderate amounts of study are positive signs since friends and grades in the new school were sources of stress and anxiety for the girl. The ability to wear clothes appropriate to the weather rather than hiding her arms is a sign she is no longer injuring her arms. Joining three clubs and being an officer in one of them is unlikely and would probably be an additional source of stress for the girl as would be pushing herself to extraordinary academic achievement to secure a place in college when she has just entered junior high.

 CN: Psychosocial integrity; CL: Evaluate;

Managing Care Quality and Safety

73. 4. Children who experience serious losses, especially multiple losses, such as old friends or a parent, are more at risk for depression. Girls also are at greater risk than boys during the adolescent years.

 CN: Health promotion and maintenance; CL: Analyze

74. 3. The nurse manager needs to focus on the frustration that the nurse is expressing. Additionally, the nurse manager needs to correct any misinformation or misinterpretation that the staff nurse has. Saying that the nurse sounds burned out and asking about a vacation does not focus on the nurse's frustration or address the inaccuracy of the nurse's statement. There is no evidence to suggest that children with conduct disorder have more than the average adult's risk of depression or anxiety. Therefore, this response is inaccurate and inappropriate. Anecdotal information from personal experience does not supply the nurse with accurate, reliable information.

 CN: Management of care; CL: Synthesize

75. 4. Indifference to other people and mutism may be indicators of autism and would require further investigation. A 2-year-old who talks to himself and refuses to cooperate with toilet training is displaying behaviors typical for this age. Occasional thumb sucking and not having spent the night with a friend would be normal at age 6. Threats to run away when angry is considered within the range of normal behaviors for a 10-year-old child.

 CN: Health promotion and maintenance; CL: Analyze

76. 1. The severe emotional trauma the girl has experienced will likely make it difficult for her to be successful in an adoptive placement at the present time, whether that placement is with someone she knows (the nurse) or another adoptive family. Additionally, adoption by the nurse is inappropriate because it blurs the lines between her professional and personal life and is likely to confuse

the client. It is clear that the client has many issues and that love alone is not likely to solve all her problems. Treatment at the residential facility will allow her to work through emotional issues in a more therapeutic environment. Though not currently ready for adoption, she may be ready for adoption in the future after sufficient treatment.

 CN: Management of care; CL: Evaluate

77. 3. Restricting intake to lose weight is a first step toward an eating disorder for males as well as females, so this behavior should be investigated further, especially since males of this age are usually unconcerned about their weight. Quick mood changes are common in young adolescents, particularly girls. Such mood changes should not be considered problematic if the adolescent is not experiencing trouble in major areas of his/her life. Experimenting with alcohol or other substances is fairly common in the teen years, but one or two uses do not generally lead to addiction. The negative effect of the coughing may be a deterrent to further use. Religious questioning and exploration of “dark” subjects is common among teens and is part of the development of mature thinking. In the absence of other signs of depression, it does not warrant further evaluation.

 CN: Management of care; CL: Evaluate

78. 2. The aide is concerned about the behavior of the client and confused about why it is occurring, so the nurse needs to explain a bit about the issues involved as well as demonstrate empathy for the aide. It is appropriate to explain that the client is not cutting for attention, but the nurse's response does not address the reason for the teen's behavior so is inadequate and sounds a little like the nurse is denigrating the aide, which will not encourage the aide to listen to what she has to say. The comments that the aide cannot work with the client or that she should transfer are punitive and do nothing to help the aide understand self-mutilation.

 CN: Management of care; CL: Analyze

PART 3
Postreview Tests

TEST 1: COMPREHENSIVE

1. A client with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome confides that he is homosexual and his employer does not know his HIV status. Which response by the nurse is **best**?

☐ **1.** "Would you like me to help you tell them?"
☐ **3.** "The information you confide in me is confidential."
☐ **3.** "I must share this information with your family."
☐ **4.** "I must share this information with your employer."

2. The mother of a child with bronchial asthma tells the nurse that the child wants a pet. Which of the following pets is **most** appropriate?

☐ **1.** Cat.
☐ **2.** Fish.
☐ **3.** Gerbil.
☐ **4.** Canary.

3. An elderly client is being admitted to same-day surgery for cataract extraction. The client has several diamond rings. The nurse should explain to the client that:

☐ **1.** The rings will be taped before the surgery.
☐ **2.** The rings will be placed in an envelope, the client will sign the envelope, and the envelope will be placed in a safe.
☐ **3.** The rings will be locked in the narcotics box.
☐ **4.** The nursing supervisor will hold onto the rings during the surgery.

4. When an infant resumes taking oral feedings after surgery to correct intussusception, the parents comment that the child seems to suck on the pacifier more since the surgery. The nurse explains that sucking on a pacifier:

☐ **1.** Provides an outlet for emotional tension.
☐ **2.** Indicates readiness to take solid foods.
☐ **3.** Indicates intestinal motility.
☐ **4.** Is an attempt to get attention from the parents.

5. Under which circumstance may a nurse communicate medical information without the client's consent?

☐ **1.** When certifying the client's absence from work.
☐ **2.** When requested by the client's family.

☐ **3.** When treating the client with a sexually transmitted disease.
☐ **4.** When prescribed by another physician.

6. A 22-year-old client is brought to the emergency department with his fiancée after being involved in a serious motor vehicle accident. His Glasgow Coma Scale score is 7, and he demonstrates evidence of decorticate posturing. Which of the following is appropriate for obtaining permission to place a catheter for intracranial pressure (ICP) monitoring?

☐ **1.** The nurse will obtain a signed consent from the client's fiancée because he is of legal age and they are engaged to be married.
☐ **2.** The physician will get a consultation from another physician and proceed with placement of the ICP catheter until the family arrives to sign the consent.
☐ **3.** Two nurses will receive a verbal consent by telephone from the client's next of kin before inserting the catheter.
☐ **4.** The physician will document the emergency nature of the client's condition and that an ICP catheter for monitoring was placed without a consent.

7. A 68-year-old client's daughter is asking about the follow-up evaluation for her father after his pneumonectomy for primary lung cancer. The nurse's **best** response is which of the following?

☐ **1.** “The usual follow-up is chest x-ray and liver function tests every 3 months.”
☐ **2.** “The follow-up for your father will be a chest x-ray and a computed tomography scan of the abdomen every year.”
☐ **3.** “No follow-up is needed at this time.”
☐ **3.** “The follow-up for your father will be a chest x-ray every 6 months.”

8. The nurse is preparing to administer blood to a client who requires postoperative blood replacement. The nurse should use a blood administration set that has a:

☐ **1.** Micron mesh filter.
☐ **2.** Nonfiltered blood administration set.
☐ **3.** Special leukocyte-poor filter.
☐ **4.** Microdrip administration set.

9. During the health history interview, which of the following strategies is the **most** effective for the nurse to use to help clients take an active role in their health care?

☐ **1.** Ask clients to complete a questionnaire.
☐ **2.** Provide clients with written instructions.

☐ **3.** Ask clients for their views of their health and health care.
☐ **4.** Ask clients if they have any questions about their health.

10. The nurse is planning care for a client who chews the fingers constantly. Before applying mitten restraints, the nurse could try which of the following interventions? Select all that apply.
☐ **1.** Ask the client to rub lotion over the hands every day after bathing.
☐ **2.** Encourage physical activity, such as ambulation.
☐ **3.** Provide frequent contacts for communication and socialization.
☐ **4.** Provide family education.
☐ **5.** Encourage involvement of family and friends.

11. A client with severe depression states, “My heart has stopped and my blood is black ash.” The nurse interprets this statement to be evidence of which of the following?
☐ **1.** Hallucination.
☐ **2.** Illusion.
☐ **3.** Delusion.
☐ **4.** Paranoia.

12. When a client wants to read the chart, the nurse should:
☐ **1.** Call the health care provider to obtain permission.
☐ **2.** Give the client the chart and answer the client's questions.
☐ **3.** Tell the client to read the chart when the doctor makes rounds.
☐ **4.** Answer any questions the client has without giving the client the chart.

13. A client with a fractured leg has been instructed to ambulate without weight bearing on the affected leg. The nurse evaluates that the client is ambulating correctly if the client uses which of the following crutch-walking gaits?
☐ **1.** Two-point gait.
☐ **2.** Four-point gait.
☐ **3.** Three-point gait.
☐ **4.** Swing-to gait.

14. A client with major depression states, “Life isn't worth living anymore. Nothing matters.” Which of the following responses by the nurse is **best**?
☐ **1.** “Are you thinking about killing yourself?”
☐ **2.** “Things will get better, you know.”
☐ **3.** “Why do you think that way?”
☐ **4.** “You shouldn't feel that way.”

15. A client with bipolar 1 disorder has been prescribed olanzapine

(Zyprexa) 5 mg two times a day and lamotrigine (Lamictal) 25 mg two times a day. Which of the following adverse effects should the nurse report to the physician immediately? Select all that apply.

☐ **1.** Rash.
☐ **2.** Nausea.
☐ **3.** Sedation.
☐ **4.** Hyperthermia.
☐ **5.** Muscle rigidity.

A client is prescribed atropine 0.4 mg intramuscularly. The atropine vial is labeled 0.5 mg/mL. How many milliliters should the nurse plan to administer?

_____ mL.

17. A multiparous client tells the nurse that she is using medroxyprogesterone (Depo-Provera) for contraception. The nurse should instruct the client to increase her intake of which of the following?

☐ **1.** Folic acid.
☐ **2.** Vitamin C.
☐ **3.** Magnesium.
☐ **4.** Calcium.

18. Which of the following statements made by a pregnant woman in the first trimester are consistent with this stage of pregnancy? Select all that apply.

☐ **3.** “My husband told his friends we will have to give up the Mustang for a minivan.”
☐ **3.** “Oh my, how did this happen? I don't need this now.”
☐ **3.** “I can't wait to see my baby. Do you think it will have my blond hair and blue eyes?”
☐ **4.** “I used a Disney theme for decorating the room.”
☐ **4.** “I wonder how it will feel to buy maternity clothes and be fat.”
☐ **6.** “We went to the mall yesterday to buy a crib and dressing table.”

19. The nurse is teaching a client about using topical gentamicin sulfate (Garamycin). Which of the following comments by the client indicates the need for additional teaching?

☐ **1.** “I will avoid being out in the sun for long periods.”
☐ **2.** “I should stop applying it once the infected area heals.”
☐ **3.** “I'll call the physician if the condition worsens.”
☐ **3.** “I should apply it to large open areas.”

20. A client takes hydrochlorothiazide (HCTZ) for treatment of hypertension. The nurse should instruct the client to report which of the

following? Select all that apply.

☐ **1.** Muscle twitching.
☐ **2.** Abdominal cramping.
☐ **3.** Diarrhea.
☐ **4.** Confusion.
☐ **5.** Lethargy.
☐ **6.** Muscle weakness.

21. A client has been taking imipramine (Tofranil) for depression for 2 days. His sister asks the nurse, “Why is he still so depressed?” Which of the following responses by the nurse is **most** appropriate?

☐ **1.** “Your brother is experiencing a very serious depression.”
☐ **2.** “I'll be sure to convey your concern to his physician.”
☐ **3.** “It takes 2 to 4 weeks for the drug to reach its full effect.”
☐ **4.** “Perhaps we need to change his medication.”

22. Which interventions should the nurse use to assist the client with grandiose delusions? Select all that apply.

☐ **1.** Accepting the client while not arguing with the delusion.
☐ **2.** Focusing on the feelings or meaning of the delusion.
☐ **3.** Focusing on events and topics based in reality.
☐ **4.** Confronting the client's beliefs.
☐ **5.** Interacting with the client only when the client is based in reality.

23. Which of the following responses is **most** helpful for a client who is euphoric, intrusive, and interrupts other clients engaged in conversations to the point where they get up and leave or walk away?

☐ **1.** “When you interrupt others, they leave the area.”
☐ **2.** “You are being rude and uncaring.”
☐ **3.** “You should remember to use your manners.”
☐ **4.** “You know better than to interrupt someone.”

24. At what time should the blood be drawn in relation to the administration of the IV dose of gentamicin sulfate (Garamycin)?

☐ **1.** 2 hours before the administration of the next IV dose.
☐ **2.** 3 hours before the administration of the next IV dose.
☐ **3.** 4 hours before the administration of the next IV dose.
☐ **4.** Just before the administration of the next IV dose.

25. Which finding requires immediate intervention when planning care for an adolescent with cystic fibrosis (CF)?

☐ **1.** Delayed puberty.
☐ **2.** Chest pain with dyspnea.

☐ **3.** Poor weight gain.
☐ **4.** Large foul-smelling bulky stools.

26. A 4-year-old is brought to the emergency department with sudden onset of a temperature of 103°F (39.5°C), sore throat, and refusal to drink. The child will not lie down and prefers to lean forward while sitting up. Which of the following should the nurse do **next**?

☐ **1.** Give 600 mg of acetaminophen (Tylenol) rectally, as prescribed.
☐ **2.** Inspect the child's throat for redness and swelling.
☐ **3.** Have an appropriate-sized tracheostomy tube readily available.
☐ **4.** Obtain a specimen for a throat culture.

27. Assessment of a client taking lithium reveals dry mouth, nausea, thirst, and mild hand tremor. Based on an analysis of these findings, which of the following should the nurse do **next**?

☐ **1.** Withhold the lithium and obtain a lithium level to determine therapeutic effectiveness.
☐ **2.** Continue the lithium and immediately notify the physician about the assessment findings.
☐ **3.** Continue the lithium and reassure the client that these temporary side effects will subside.
☐ **4.** Withhold the lithium and monitor the client for signs and symptoms of increasing toxicity.

28. A client asks the nurse how long will it be necessary to take the medicine for hypothyroidism. The nurse's response is based on the knowledge that:

☐ **1.** Lifelong daily medicine is necessary.
☐ **2.** The medication is expensive, and the dose can be reduced in a few months.
☐ **3.** The medication can be gradually withdrawn in 1 to 2 years.
☐ **4.** The medication can be discontinued after the client's thyroid-stimulating hormone (TSH) level is normal.

29. The nurse should advise which of the following clients who is taking lithium to consult with the physician regarding a potential adjustment in lithium dosage?

☐ **1.** A client who continues work as a computer programmer.
☐ **2.** A client who attends college classes.
☐ **3.** A client who can now care for her children.
☐ **3.** A client who is beginning training for a tennis team.

30. The nurse is discharging a client who has been hospitalized for preterm

labor. The client needs further instruction when she says:

☐ **1.** "If I think I have a bladder infection, I need to see my obstetrician."
☐ **2.** "If I have contractions, I should contact my health care provider."
☐ **3.** "Drinking water may help prevent early labor for me."
☐ **4.** "If I travel on long trips, I need to get out of the car every 4 hours."

31. A client admitted with a gastric ulcer has been vomiting bright red blood. The hemoglobin level is 5.11 g/dL (51 g/L), and blood pressure is 100/50 mm Hg. The client and family state that their religious beliefs do not support the use of blood products and refuse blood transfusions as a treatment for the bleeding. The nurse should collaborate with the physician and family to **next:**

☐ **1.** Discontinue all measures.
☐ **2.** Notify the hospital attorney.
☐ **3.** Attempt to stabilize the client through the use of fluid replacement.
☐ **4.** Give enough blood to keep the client from dying.

32. The parents of a child with cystic fibrosis express concern about how the disease was transmitted to their child. The nurse should explain that:

☐ **1.** A disease carrier also has the disease.
☐ **2.** Two parents who are carriers may produce a child who has the disease.
☐ **3.** A disease carrier and an affected person will never have children with the disease.
☐ **4.** A disease carrier and an affected person will have a child with the disease.

33. A client with angina shows the nurse the nitroglycerin (Nitrostat) that the client carries in a plastic bag in a pocket. The nurse instructs the client that nitroglycerin should be kept in:

☐ **1.** The refrigerator.
☐ **2.** A cool, moist place.
☐ **3.** A dark container to shield from light.
☐ **4.** A plastic pill container where it is readily available.

34. When teaching a client with bipolar disorder who has started to take valproic acid about possible side effects of this medication, the nurse should instruct the client to report:

☐ **1.** Increased urination.
☐ **2.** Slowed thinking.
☐ **3.** Sedation.
☐ **4.** Weight loss.

35. An infant is born with facial abnormalities, growth retardation, mental retardation, and vision abnormalities. These abnormalities are likely caused by maternal:

☐ **1.** Alcohol consumption.
☐ **2.** Vitamin B_6 deficiency.
☐ **3.** Vitamin A deficiency.
☐ **4.** Folic acid deficiency.

36. Nonsteroidal anti-inflammatory drugs (NSAIDs) are commonly used in the treatment of musculoskeletal conditions. It is important for the nurse to remind the client to:
☐ **1.** Take NSAIDs at least three times per day.
☐ **2.** Exercise the joints at least 1 hour after taking the medication.
☐ **3.** Take antacids 1 hour after taking NSAIDs.
☐ **4.** Take NSAIDs with food.

37. The nurse should suspect that the client taking disulfiram (Antabuse) has ingested alcohol when the client exhibits which of the following symptoms?
☐ **1.** Sore throat and muscle aches.
☐ **2.** Nausea and flushing of the face and neck.
☐ **3.** Fever and muscle soreness.
☐ **4.** Bradycardia and vertigo.

38. The nurse holds the gauze pledget against an IM injection site while removing the needle from the muscle. This technique helps to:
☐ **1.** Seal off the track left by the needle in the tissue.
☐ **2.** Speed the spread of the medication in the tissue.
☐ **3.** Avoid the discomfort of the needle pulling on the skin.
☐ **4.** Prevent organisms from entering the body through the skin puncture.

39. A client whose condition remains stable after a myocardial infarction gradually increases activity. Which the following conditions should the nurse assess to determine whether the activity is appropriate for the client?
☐ **1.** Edema.
☐ **2.** Cyanosis.
☐ **3.** Dyspnea.
☐ **4.** Weight loss.

40. The nurse is conducting a counseling session with a client experiencing posttraumatic stress disorder (PSTD) using a 2-way video telehealth system from the hospital to the client's home, which is 2 hours away from the nearest mental health facility. Which of the following are expected outcomes of using telehealth as a venue to provide health care to this client? Select all that apply. The client will:
☐ **1.** Save travel time from the house to the health care facility.

☐ **2.** Avoid reliving a traumatic event that might be precipitated by visiting a health care facility.
☐ **3.** Experience a shorter recovery time than being treated on-site at a health care facility.
☐ **4.** Receive health care for this mental health problem.
☐ **5.** Obtain group support from others with a similar health problem.

41. When a client with alcohol dependency begins to talk about not having a problem with alcohol, the nurse should use which of the following approaches?
☐ **1.** Questioning the client about how much alcohol the client consumes each day.
☐ **2.** Confronting the client about being intoxicated 2 days ago.
☐ **3.** Pointing out how alcohol has gotten the client into trouble.
☐ **4.** Listening to what the client states and then asking the client about plans for staying sober.

42. The nurse is caring for a toddler in contact isolation for respiratory syncytial virus (RSV). In what order should the nurse remove personal protective equipment (PPE)?

1. Gloves.
2. Goggles.
3. Gown.
4. Mask.

43. The nurse is preparing a teaching plan for a 45-year-old client recently diagnosed with type 2 diabetes mellitus. What is the **first** step in this process?
☐ **1.** Establish goals.

☐ **2.** Choose video materials and brochures.
☐ **3.** Assess the client's learning needs.
☐ **4.** Set priorities of learning needs.

44. A loading dose of digoxin (Lanoxin) is given to a client newly diagnosed with atrial fibrillation. The nurse instructs the client about the medication and the importance of monitoring his heart rate. An expected outcome of this instruction is:
☐ **1.** A return demonstration of palpating the radial pulse.
☐ **2.** A return demonstration of how to take the medication.
☐ **3.** Verbalization of why the client has atrial fibrillation.
☐ **4.** Verbalization of the need for the medication.

45. A multigravid client is scheduled for a percutaneous umbilical blood sampling procedure. The nurse instructs the client that this procedure is useful for diagnosing which of the following?
☐ **1.** Twin pregnancies.
☐ **2.** Fetal lung maturation.
☐ **3.** Rh disease.
☐ **4.** Alpha fetoprotein level.

46. Which of the following is an adverse effect of vancomycin (Vancocin) and needs to be reported promptly?
☐ **1.** Vertigo.
☐ **2.** Tinnitus.
☐ **3.** Muscle stiffness.
☐ **4.** Ataxia.

47. Which of the following statements indicates that the client with a peptic ulcer understands the dietary modifications to follow at home?
☐ **1.** “I should eat a bland, soft diet.”
☐ **2.** “It is important to eat six small meals a day.”
☐ **3.** “I should drink several glasses of milk a day.”
☐ **4.** “I should avoid alcohol and caffeine.”

48. The client with a nasogastric (NG) tube has abdominal distention. Which of the following measures should the nurse do **first**?
☐ **1.** Call the physician.
☐ **2.** Irrigate the NG tube.
☐ **3.** Check the function of the suction equipment.
☐ **4.** Reposition the NG tube.

49. A male client has been diagnosed as having a low sperm count during

infertility studies. After instructions by the nurse about some causes of low sperm counts, the nurse determines that the client needs further instructions when he says low sperm counts may be caused by which of the following?

☐ **1.** Varicocele.
☐ **2.** Frequent use of saunas.
☐ **3.** Endocrine imbalances.
☐ **4.** Decreased body temperature.

50. A nurse is relieving the triage nurse in the labor and birth unit who is going to lunch. The report indicates that there are three clients having their vital signs assessed and a fourth client is on her way to the unit from the emergency department. In which order of priority should the nurse manage these clients?

1. The client with clear vesicles and brown vaginal discharge at 16 weeks' gestation.

2. The client with right lower quadrant pain at 10 weeks' gestation.

3. The client who is at term and has had no fetal movement for 2 days.

4. The client from the emergency department at term and screaming loudly because of labor contractions.

51. During the process of restraining a client, a staff member is injured. The nurse manager would conclude that a peer support program has been helpful for the injured staff member if which of the following outcomes had been achieved? Select all that apply.

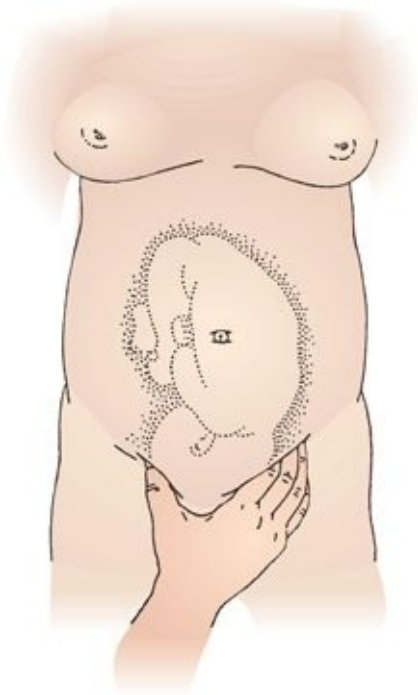
☐ **1.** The injured staff member has debriefed with the other staff involved in the restraint.
☐ **2.** Legal action has been taken against the client.

☐ **3.** The injured staff member had the opportunity to express his or her feeling with a support group.
☐ **4.** The injured staff member has decided whether or not to talk to the assaultive client.
☐ **5.** A plan has been arranged to facilitate the return of the injured staff member to work.

52. A client with severe osteoarthritis and decreased mobility is transferred to an assisted living facility. The nurse notices that the client smells of alcohol, exhibits an unsteady gait, and has six wine bottles in the trash. The client tells the nurse, “Those are my other pain medicines.” Which of the following statements by the nurse are most appropriate? Select all that apply.
☐ **1.** “I didn't realize that your pain was not being managed with your current medications.”
☐ **2.** “It is important for me to know how many bottles of wine you drank this week.”
☐ **3.** “I'm worried about the amount of wine you are drinking and its effects on your balance.”
☐ **4.** “How are you getting all this wine?”
☐ **5.** “I am calling your doctor to have all of us to talk about better pain control without the wine.”

53. When teaching unlicensed assistive personnel (UAP) about the importance of handwashing in preventing disease, the nurse should instruct the UAP that:
☐ **1.** “It is not necessary to wash your hands as long as you use gloves.”
☐ **2.** “Hand washing is the best method for preventing cross-contamination.”
☐ **3.** “Waterless commercial products are not effective for killing organisms.”
☐ **4.** “The hands do not serve as a source of infection.”

54. The nurse is performing Leopold's maneuvers on a woman who is in her eighth month of pregnancy. The nurse is palpating the uterus as shown below. Which of the following maneuvers is the nurse performing?
☐ **1.** First maneuver.
☐ **2.** Second maneuver.
☐ **3.** Third maneuver.
☐ **4.** Fourth maneuver.



55. A client in cardiac rehabilitation would like to eat the right foods to ensure adequate endurance on the treadmill. Which of the following nutrients is **most** helpful for promoting endurance during sustained activity?

☐ **1.** Protein.
☐ **2.** Carbohydrate.
☐ **3.** Fat.
☐ **4.** Water.

56. A client's chest tube is connected to a drainage system with a water seal. The nurse notes that the fluid in the water-seal column is fluctuating with each breath that the client takes. The fluctuation means that:

☐ **1.** There is an obstruction in the chest tube.
☐ **2.** The client is developing subcutaneous emphysema.
☐ **3.** The chest tube system is functioning properly.
☐ **4.** There is a leak in the chest tube system.

57. A client with diabetes is explaining to the nurse how to care for the feet at home. Which statement indicates that the client understands proper foot care?

☐ **1.** “When I injure my toe, I will plan to put iodine on it.”
☐ **2.** “I should inspect my feet at least once a week.”
☐ **3.** “It is okay to go barefoot in the house.”
☐ **4.** “It is important to dry my feet carefully after my bath.”

58. The nurse assesses a client with diverticulitis. The nurse should report which of the following to the health care provider?

☐ **1.** Hyperactive bowel sounds.
☐ **2.** Rigid abdominal wall.
☐ **3.** Explosive diarrhea.
☐ **4.** Excessive flatulence.

59. A nurse is assessing a client who has a potential diagnosis of pancreatitis. Which risk factors predispose the client to pancreatitis? Select all that apply.

☐ **1.** Excessive alcohol use.
☐ **2.** Gallstones.
☐ **3.** Abdominal trauma.
☐ **4.** Hypertension.
☐ **5.** Hyperlipidemia with excessive triglycerides.
☐ **6.** Hypothyroidism.

60. The nurse is beginning the shift and is planning care for 6 clients on the postpartum unit. Three of the clients have immediate needs and three of the clients are listed as “stable.” For the best utilization of time and client safety, the nurse should make rounds on which of the following clients **first**?

☐ **1.** The three clients who are reported to be stable.
☐ **2.** The mother with a 4-hour-old infant with initial blood glucose of 33 mg/dL (1.8 mmol/L) and now at 45 mg/dL (2.5 mmol/L) breast-feeding her infant.
☐ **3.** A mother who had a spontaneous vaginal birth (SVB) and received carboprost 1 hour ago for increased bleeding.
☐ **4.** A mother with a 3-day-old who had a bilirubin level of 13 mg/dL (1149.2 µmol/L) 30 minutes ago and is now in a “biliblanket” at the mother's bedside.

61. When performing chest percussion on a child, which of the following techniques should the nurse use?

☐ **1.** Firmly but gently striking the chest wall to make a popping sound.
☐ **2.** Gently striking the chest wall to make a slapping sound.
☐ **3.** Percussing over an area from the umbilicus to the clavicle.
☐ **4.** Placing a blanket between the nurse's hand and the child's chest.

62. The nurse walks into the room of a client who has a “do not resuscitate” prescription and finds the client without a pulse, respirations, or blood pressure. The nurse should first?

☐ **1.** Stay in the room and call the nursing team for assistance.

☐ **2.** Push the emergency alarm to call a code.
☐ **3.** Page the client's physician.
☐ **4.** Pull the curtain and leave the room.

A client is trying to lose weight at a moderate pace. If the client eliminates 1,000 cal/day from his normal intake, how many pounds (or kilograms) would the client lose in 1 week?

_____ lbs/kgs.

64. A nulligravid client calls the clinic and tells the nurse that she forgot to take her oral contraceptive this morning. Which of the following should the nurse instruct the client to do?
☐ **1.** Take the medication immediately.
☐ **2.** Restart the medication in the morning.
☐ **3.** Use another form of contraception for 2 weeks.
☐ **4.** Take two pills tonight before bedtime.

65. The nurse recognizes that a client with pain disorder is improving when the client says which of the following?
☐ **1.** “I need to have a good cry about all the pain I've been in and then not dwell on it.”
☐ **2.** “I need to find another physician who can accurately diagnose my condition.”
☐ **3.** “The pain medicine that you gave me helps me to relax.”
☐ **4.** “I'm angry with all of the doctors I've seen who don't know what they're doing.”

66. A client admitted in an acute psychotic state hears terrible voices in the head and thinks a neighbor is upset with the client. Which of the following is the nurse's **best** response?
☐ **1.** “What has your neighbor been doing that bothers you?”
☐ **2.** “How long have you been hearing these terrible voices?”
☐ **3.** “We won't let your neighbor visit, so you'll be safe.”
☐ **4.** “What exactly are these terrible voices saying to you?”

67. The nurse should assess the client with severe diarrhea for which acid-base imbalance?
☐ **1.** Respiratory acidosis.
☐ **2.** Respiratory alkalosis.
☐ **3.** Metabolic acidosis.
☐ **4.** Metabolic alkalosis.

68. A nurse is planning care for a client who has heart failure. Which goal is

appropriate for a client with excess fluid volume?

☐ **1.** A weight reduction of 10% will occur.
☐ **2.** Pain will be controlled effectively.
☐ **3.** Arterial blood gas values will be within normal limits.
☐ **4.** Serum osmolality will be within normal limits.

69. A 7-year-old child is admitted to the hospital with the diagnosis of acute rheumatic fever. Which of the following laboratory blood findings confirms that the child has had a streptococcal infection?

☐ **1.** High leukocyte count.
☐ **2.** Low hemoglobin count.
☐ **3.** Elevated antibody concentration.
☐ **4.** Low erythrocyte sedimentation rate.

70. The nurse on the postpartum unit is caring for four couplets. There will be a new admission in 30 minutes. The new client is a G4 P4, Spanish-speaking only client with an infant who is in the special care nursery (SCN) for fetal distress. The nurse should place the new client in a room with which of the following clients?

☐ **1.** A G4 P4 who is 2 days postpartum with infant, Spanish speaking only.
☐ **2.** A G1 P1 who is 1 day postpartum with an infant in the SCN.
☐ **3.** A G6 P6 who gave birth 4 hours ago by C/S for fetal distress, infant at bedside.
☐ **4.** A G1 P1 who is a non–English-speaking client with infant in SCN for fetal distress.

71. A client scheduled for hip replacement surgery wishes to receive his own blood for the upcoming surgery. The nurse should:

☐ **1.** Document the client's request on the chart.
☐ **2.** Notify the hematology laboratory.
☐ **3.** Notify the surgeon's office.
☐ **4.** Call the blood bank.

72. A client is scheduled to have surgery to relieve an intestinal obstruction. Prior to surgery the nurse should verify that the client has:

☐ **1.** Discontinued use of blood thinners.
☐ **2.** Followed a low-residue diet.
☐ **3.** Performed abdominal tightening exercises.
☐ **4.** Signed a last will and testament.

73. After teaching a client about collecting a stool sample for occult testing, which client statement indicates effective teaching? Select all that apply.

☐ **1.** “I will avoid eating meat for 1 to 3 days before getting a stool sample.”

☐ **2.** “I need to eat foods low in fiber a few days before collecting the sample.”
☐ **3.** “I'll take the sample from different areas of the stool that I have passed.”
☐ **4.** “I need to send the stool sample to the lab in a covered container right away.”
☐ **5.** “I can continue to take all of my regular medications at home.”

74. A client who is on nothing-by-mouth (NPO) status is constantly asking for a drink of water. Which of the following is the **most** appropriate nursing intervention?
☐ **1.** Reexplain why it is not possible to have a drink of water.
☐ **2.** Offer ice chips every hour to decrease thirst.
☐ **3.** Offer the client frequent oral hygiene care.
☐ **4.** Divert the client's attention by turning on the television.

75. A female client is admitted with fatigue, cold intolerance, weight gain, and muscle weakness. The initial nursing assessment reveals brittle nails, dry hair, constipation, and possible goiter. The nurse should conduct a focused assessment for further signs of:
☐ **1.** Cushing's disease.
☐ **2.** Hypothyroidism.
☐ **3.** Hyperthyroidism.
☐ **4.** A pituitary tumor.

76. A mother tells the nurse that her 10-year-old daughter has an increase in hair growth and breast enlargement. The nurse explains to the mother and daughter that after the symptoms of puberty are noticed, menstruation typically occurs within which of the following time frames?
☐ **1.** 6 months.
☐ **2.** 12 months.
☐ **3.** 30 months.
☐ **4.** 36 months.

77. While a mother is feeding her full-term neonate 1 hour after birth, she asks the nurse, “What are these white dots in my baby's mouth? I tried to wash them out, but they're still there.” After assessing the neonate's mouth, the nurse explains that these spots are which of the following?
☐ **1.** Koplik's spots.
☐ **2.** Epstein's pearls.
☐ **3.** Precocious teeth.
☐ **4.** Thrush curds.

78. The nurse should assess a newborn with esophageal atresia and tracheoesophageal fistula (TEF) for which of the following? Select all that apply.

☐ **1.** Copious frothy mucus.
☐ **2.** Episodes of cyanosis.
☐ **3.** Several loose stools.
☐ **4.** Initial weight loss.
☐ **5.** Poor gag reflex.

79. Which of the following factors is **most** important for healing an infected decubitus ulcer?
☐ **1.** Adequate circulatory status.
☐ **2.** Scheduled periods of rest.
☐ **3.** Balanced nutritional diet.
☐ **4.** Fluid intake of 1,500 mL/day.

80. A client is receiving digoxin (Lanoxin) and the pulse range is normally 70 to 76 bpm. After assessing the apical pulse for 1 minute and finding it to be 60 bpm, the nurse should **first**:
☐ **1.** Notify the physician.
☐ **2.** Withhold the digoxin.
☐ **3.** Administer the digoxin.
☐ **4.** Notify the charge nurse.

81. The nurse hears a pregnant client yell, “Oh my! The baby's coming!” After placing the client in a supine position and trying to maintain some privacy, the nurse sees that the neonate's head is being born. Which of the following should the nurse do **first**?
☐ **1.** Suction the mouth with two fingertips.
☐ **2.** Check for presence of a cord around the neck.
☐ **3.** Tell the client to bear down with force.
☐ **4.** Advise the mother that help is on the way.

82. The nurse is preparing a discharge plan for a 16-year-old who has fractured the femur and ulna. The client asks the nurse how quickly the fractures will heal. Which of the following responses is **most** appropriate for the nurse to make?
☐ **1.** “The healing of your leg will be delayed because you have had skeletal traction.”
☐ **2.** “It will take your arm about 12 weeks to heal completely, but it will take your leg about 24 weeks.”
☐ **3.** “Because you are young and healthy, your bones should heal in less than 12 weeks.”
☐ **4.** “You will require long-term rehabilitation and should expect it to take at least 8 months for your bones to heal.”

83. A client with delirium becomes very anxious and says, “I can't stop what is happening to me. Make it stop, please!” Which of the following is the nurse's **most** appropriate response?

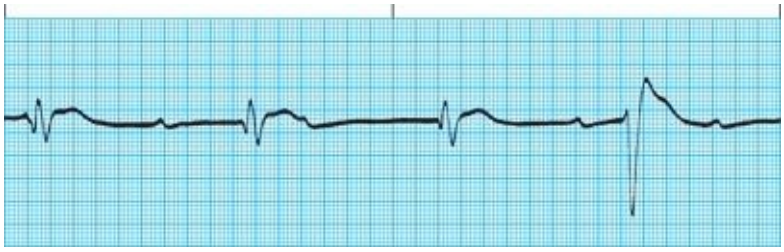
☐ **1.** “I'll get you some medicine to help you relax. The more you worry, the worse it will get.”
☐ **2.** “As soon as we know what's causing this, we can try to stop it. I'll get you some medicine to help you relax.”
☐ **3.** “I wish I could do something to make it stop, but unfortunately I can't.”
☐ **4.** “I'll sit with you until you calm down a little.”

84. After teaching a primigravid client at 10 weeks' gestation about the recommendations for exercise during pregnancy, which of the following client statements indicates successful teaching?

☐ **1.** “While pregnant, I should avoid contact sports.”
☐ **2.** “Even though I'm pregnant, I can learn to ski next month.”
☐ **3.** “While we are on vacation next month, I can continue to scuba dive.”
☐ **4.** “Sitting in a hot tub after exercise will help me to relax.”

85. The nurse is assessing a client who has had a myocardial infarction. The nurse notes the cardiac rhythm shown below. The nurse identifies that this rhythm is:

☐ **1.** Atrial fibrillation.
☐ **2.** Ventricular tachycardia.
☐ **3.** Premature ventricular contractions.
☐ **4.** Third-degree heart block.



86. The physician has prescribed a chemotherapy drug to be administered to a client every day for the next week. The client is on an adult medical-surgical floor, but the nurse assigned to the client has not been trained to handle chemotherapy agents. What is the nurse's **most** appropriate response?

☐ **1.** Send the client to the oncology floor for administration of the medication.
☐ **2.** Ask a nurse from the oncology floor to come to the client and administer the medication.

☐ **3.** Ask another nurse to help mix the chemotherapy agent.
☐ **4.** Ask the pharmacy to mix the chemotherapy agent and administer it.

87. Which of the following is a **priority** goal after surgical repair of a cleft lip?
☐ **1.** Managing pain.
☐ **2.** Preventing infection.
☐ **3.** Increasing mobility.
☐ **4.** Developing parenting skills.

88. Which of the following is an appropriate outcome for a client with rheumatoid arthritis?
☐ **1.** The client will manage joint pain and fatigue to perform activities of daily living.
☐ **2.** The client will maintain full range of motion in joints.
☐ **3.** The client will prevent the development of further pain and joint deformity.
☐ **4.** The client will take anti-inflammatory medications as indicated by the presence of disease symptoms.

89. A client's burn wounds are being cleaned twice a day in a hydrotherapy tub. Which of the following interventions should be included in the plan of care before a hydrotherapy treatment is initiated?
☐ **1.** Limit food and fluids 45 minutes before therapy to prevent nausea and vomiting.
☐ **2.** Increase the IV flow rate to offset fluids lost through the therapy.
☐ **3.** Apply a topical antibiotic cream to burns to prevent infection.
☐ **4.** Administer pain medication 30 minutes before therapy to help manage pain.

90. A health care provider has been exposed to hepatitis B through a needlestick. Which of the following drugs should the nurse anticipate administering as postexposure prophylaxis?
☐ **3.** Hepatitis B immune globulin.
☐ **2.** Interferon.
☐ **3.** Hepatitis B surface antigen.
☐ **4.** Amphotericin B.

91. When performing an otoscopic examination of the tympanic membrane of a 2-year-old child, the nurse should pull the pinna in which of the following directions?
☐ **1.** Down and back.
☐ **2.** Down and slightly forward.

☐ **3.** Up and back.
☐ **4.** Up and forward.

92. Which of the following findings should the nurse note in the client who is in the compensatory stage of shock?
☐ **1.** Decreased urinary output.
☐ **2.** Significant hypotension.
☐ **3.** Tachycardia.
☐ **4.** Mental confusion.

93. A client has been prescribed hydrochlorothiazide (HydroDIURIL) to treat heart failure. For which of the following symptoms should the nurse monitor the client?
☐ **1.** Urinary retention.
☐ **2.** Muscle weakness.
☐ **3.** Confusion.
☐ **4.** Diaphoresis.

94. The son of a client with Alzheimer's disease excitedly tells the nurse, “Mom was singing one of her favorite old songs. I think she's getting her memory back!” Which of the following responses by the nurse is **most** appropriate?
☐ **1.** “She still has long-term memory, but her short-term memory will not return.”
☐ **2.** “I'm so happy to hear that. Maybe she is getting better.”
☐ **3.** “Don't get your hopes up. This is only a temporary improvement.”
☐ **4.** “I'm glad she can sing even if she can't talk to you.”

95. The nurse collects a urine specimen from a client for a culture and sensitivity analysis. Which of the following is the correct care of the specimen?
☐ **1.** Promptly send the specimen to the laboratory.
☐ **2.** Send the specimen with the next pickup.
☐ **3.** Send the specimen the next time a nursing assistant is available.
☐ **4.** Store the specimen in the refrigerator until it can be sent to the laboratory.

96. A 16-year-old client is in the emergency department for treatment of minor injuries from a car accident. A crisis nurse is with the client because the client became hysterical and was saying, “It's my fault. My Mom is going to kill me. I don't even have a way home.” Which of the following should be the nurse's **initial** intervention?
☐ **1.** Hold her hands and say, “Slow down. Take a deep breath.”
☐ **2.** Say, “Calm down. The police can take you home.”
☐ **3.** Put a hand on her shoulder and say, “It wasn't your fault.”

☐ **4.** Say, “Your mother is not going to kill you. Stop worrying.”

97. The nurse is developing a community health education program about sexually transmitted diseases. Which information about women who acquire gonorrhea should be included?

☐ **1.** Women are more reluctant than men to seek medical treatment.
☐ **2.** Gonorrhea is not easily transmitted to women who are menopausal.
☐ **3.** Women with gonorrhea are usually asymptomatic.
☐ **4.** Gonorrhea is usually a mild disease for women.

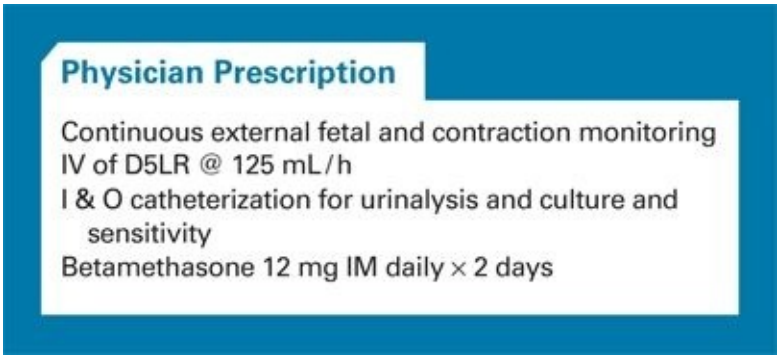
98. A client has the leg immobilized in a long leg cast. Which of the following assessments indicates the early beginning of circulatory impairment?

☐ **1.** Inability to move toes.
☐ **2.** Cyanosis of toes.
☐ **3.** Sensation of cast tightness.
☐ **4.** Tingling of toes.

99. A client tells the nurse that she has had sexual contact with someone whom she suspects has genital herpes. Which of the following instructions should the nurse give the client in response to this information?

☐ **1.** Anticipate lesions within 25 to 30 days.
☐ **2.** Continue sexual activity unless lesions are present.
☐ **3.** Report any difficulty urinating.
☐ **4.** Drink extra fluids to prevent lesions from forming.

100. A multigravid client at 34 weeks' gestation who is leaking amniotic fluid has just been hospitalized with a diagnosis of preterm premature rupture of membranes and preterm labor. The client's contractions are 20 minutes apart, lasting 20 to 30 seconds. Her cervix is dilated to 2 cm. The nurse reviews the physician prescriptions (see chart). Which of the following prescriptions should the nurse initiate **first**?



☐ **1.** Initiate fetal and contraction monitoring.
☐ **2.** Start the intravenous infusion.

☐ **3.** Obtain the urine specimen.
☐ **4.** Administer betamethasone.

101. The nurse is assessing a client with irreversible shock. The nurse should document which of the following?
☐ **1.** Increased alertness.
☐ **2.** Circulatory collapse.
☐ **3.** Hypertension.
☐ **4.** Diuresis.

102. The nurse is caring for a client who has been diagnosed with deep vein thrombosis. When assessing the client's vital signs, the nurse notes an apical pulse of 150 bpm, a respiratory rate of 46 breaths/min, and blood pressure of 100/60 mm Hg. The client appears anxious and restless. What should be the nurse's **first** course of action?
☐ **1.** Notify the physician.
☐ **2.** Administer a sedative.
☐ **3.** Try to elicit a positive Homans' sign.
☐ **4.** Increase the flow rate of intravenous fluids.

103. A client who has Ménière's disease is trying to cope with chronic tinnitus. Which of the following interventions is **most** appropriate for the nurse to suggest for coping with the tinnitus?
☐ **1.** Maintain a quiet environment.
☐ **2.** Play background music.
☐ **3.** Avoid caffeine and nicotine.
☐ **4.** Take a mild sedative.

104. A 4-year-old child who has been ill for 4 hours is admitted to the hospital with difficulty swallowing, a sore throat, and severe substernal retractions. The child's temperature is 104°F (40°C), and the apical pulse is 140 bpm. The white blood cell count is 16,000/mm^3 (16 × 10^9/L). Which of the following is the **priority** for nursing intervention?
☐ **1.** Anxiety.
☐ **2.** Airway obstruction.
☐ **3.** Difficulty breathing.
☐ **4.** Potential for aspiration.

105. The nurse is conducting walking rounds and observes the client (see figure). The nurse should do which of the following?
☐ **1.** Loosen the bed restraints so the client can sit up.
☐ **2.** Raise the side rails to full upright position.

☐ **3.** Assess the client to determine why she wants to sit up.
☐ **4.** Elevate the head of the bed.

106. The nurse caring for a client with diabetes realizes that the client has a higher risk of developing cataracts and should also assess the client for indications of:
☐ **1.** Background retinopathy.
☐ **2.** Proliferative retinopathy.
☐ **3.** Neuropathy.
☐ **4.** Diabetic retinopathy.

107. Of the following clients, which client is at **greatest** risk for falling?
☐ **1.** A 22-year-old man with three fractured ribs and a fractured left arm.
☐ **2.** A 70-year-old woman with episodes of syncope.
☐ **3.** A 50-year-old man with angina.
☐ **4.** A 30-year-old woman with a fractured ankle.

108. Which of the following baseline laboratory data should be established before a client is started on tissue plasminogen activator or alteplase recombinant (Activase)?
☐ **1.** Potassium level.
☐ **2.** Lee-White clotting time.
☐ **3.** Hemoglobin level, hematocrit, and platelet count.
☐ **4.** Blood glucose level.

109. The nurse is developing an education plan for clients with hypertension. Which of the following long-term goals is **most** appropriate for the nurse to emphasize?

☐ **1.** Develop a plan to limit stress.
☐ **2.** Participate in a weight reduction program.
☐ **3.** Commit to lifelong therapy.
☐ **4.** Monitor blood pressure regularly.

110. The nurse should consider which of the following principles when developing a plan of care to manage a client's pain from cancer?

☐ **1.** Individualize the pain medication regimen for the client.
☐ **2.** Select medications that are least likely to lead to addiction.
☐ **3.** Administer pain medication as soon as the client requests it.
☐ **4.** Change pain medications periodically to avoid drug tolerance.

111. After explaining to a multigravid client at 36 weeks' gestation who is diagnosed with severe hydramnios about the possible complications of this condition, which of the following statements indicates that the client needs further instruction?

☐ **1.** “Because I have hydramnios, I may gain weight.”
☐ **2.** “Hydramnios has been associated with gastrointestinal disorders in the fetus.”
☐ **3.** “I should continue to eat high-fiber foods and avoid constipation.”
☐ **4.** “I can continue to work at my job at the automobile factory until labor starts.”

112. An obese diabetic client has bilateral leg aching and is to start a cardiac rehabilitation to start an exercise program. Which of the following activities is **most** helpful for the client?

☐ **1.** Interval training on the stationary bicycle.
☐ **2.** Interval training on the treadmill.
☐ **3.** Interval training on a commercial ski machine.
☐ **4.** Interval training on the stair climber.

113. The nurse is assigned to a client with jaundice and collects the following data: poor appetite, nausea, and two episodes of emesis in the past 2 hours. The client reports having spasms in the stomach area. The nurse should develop a care plan for which of the following health problems **first**?

☐ **1.** Nausea.
☐ **2.** Poor appetite.
☐ **3.** Jaundice.
☐ **4.** Abdominal spasms.

114. Which of the following is recommended protocol for all clients who are at risk for pressure sore development?

☐ **1.** Identify at-risk clients on admission to the health care facility.
☐ **2.** Place at-risk clients on an every-2-hour turning schedule.
☐ **3.** Automatically place clients in specialty beds.
☐ **4.** Provide at-risk clients with a high-protein, high-carbohydrate diet.

115. A client has been prescribed digoxin (Lanoxin). Which of the following symptoms should the nurse tell the client to report as a potential indication of digoxin toxicity?

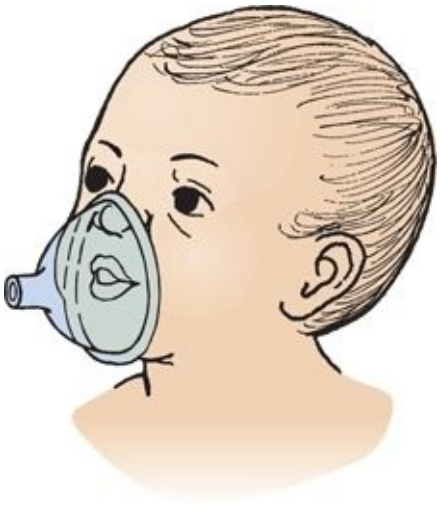
☐ **1.** Urticaria.
☐ **2.** Shortness of breath.
☐ **3.** Visual disturbances.
☐ **4.** Hypertension.

116. The nurse is instructing a client on how to care for skin that has become dry after radiation therapy. Which of the following statements by the client indicates that the client understands the teaching?

☐ **1.** “I should take antihistamines to decrease the itching I am experiencing.”
☐ **2.** “It is safe to apply a nonperfumed lotion to my skin.”
☐ **3.** “A heating pad, set on the lowest setting, will help decrease my discomfort.”
☐ **4.** “I can apply an over-the-counter cortisone ointment to relieve the dryness.”

117. A neonate is experiencing respiratory distress and is using a neonatal oxygen mask. An unlicensed assistive personnel has positioned the oxygen mask as shown below. The nurse is assessing the neonate and determines that the mask:

☐ **1.** Is appropriate for the neonate.
☐ **2.** Is too large because it covers the neonate's eyes.
☐ **3.** Is too small because it is obstructing the nose.
☐ **4.** Should be covered with a soft cloth before being placed against the skin.



118. The nurse is preparing a client for a thoracentesis. How should the nurse position the client for the procedure?

☐ **1.** Supine with the arms over the head.
☐ **2.** Sims' position.
☐ **3.** Prone position without a pillow.
☐ **4.** Sitting forward with the arms supported on the bedside table.

119. The antidote for heparin is:

☐ **1.** Vitamin K.
☐ **2.** Warfarin (Coumadin).
☐ **3.** Thrombin.
☐ **4.** Protamine sulfate.

120. Which of the following actions is **most** appropriate when dealing with a client who is expressing anger verbally, is pacing, and is irritable?

☐ **1.** Conveying empathy and encouraging ventilation.
☐ **2.** Using calm, firm directions to get the client to a quiet room.
☐ **3.** Putting the client in restraints.
☐ **4.** Discussing alternative strategies for when the client is angry in the future.

121. Which of the following measures should be implemented promptly after a client's nasogastric (NG) tube has been removed?

☐ **1.** Provide the client with oral hygiene.
☐ **2.** Offer the client liquids to drink.
☐ **3.** Encourage the client to cough and deep breathe.
☐ **4.** Auscultate the client's bowel sounds.

122. The nurse applies warm compresses to a client's leg. To determine

effectiveness of the compresses, the nurse should determine if there is:

☐ **1.** Less scaling on the skin.
☐ **2.** Decreased bruising.
☐ **3.** Improved circulation to the area.
☐ **4.** Decreased swelling in the area.

123. While assisting the physician with an amniocentesis on a multigravid client at 38 weeks' gestation, the nurse observes that the fluid is very cloudy and thick. The nurse interprets this finding as indicating which of the following?

☐ **1.** Intrauterine infection.
☐ **2.** Fetal meconium staining.
☐ **3.** Erythroblastosis fetalis.
☐ **4.** Normal amniotic fluid.

124. The nurse instructs the unlicensed assistive personnel on how to collect a 24-hour urine specimen. Which of the following instructions is correct for a collection that is scheduled to start at 7 AM Monday and end at 7 AM Tuesday?

☐ **1.** Collect and save the urine voided at 7 AM on Monday.
☐ **2.** Send the first voided urine specimen on Monday to the laboratory for culture.
☐ **3.** Collect and save the urine voided at 7 AM on Tuesday.
☐ **4.** Keep each day's urine collection in separate containers.

125. Which of the following laboratory values for a client with cirrhosis who has developed ascites should the nurse report to the health care provider?

☐ **1.** Decreased aspartate aminotransferase.
☐ **2.** Hypoalbuminemia.
☐ **3.** Hyperkalemia.
☐ **4.** Decreased alanine aminotransferase.

126. An infant is to receive the diphtheria, tetanus, and acellular pertussis (DTaP) and inactivated polio vaccine (IPV) immunizations. The child is recovering from a cold and is afebrile. The child's sibling has cancer and is receiving chemotherapy. Which of the following actions is **most** appropriate?

☐ **1.** Giving the DTaP and withholding the IPV.
☐ **2.** Administering the DTaP and IPV immunizations.
☐ **3.** Postponing both immunizations until the sibling is in remission.
☐ **4.** Withholding both immunizations until the infant is well.

127. When creating a program to decrease the primary cause of disability and death in children, which of the following is **most** effective for the community health nurse to do?

☐ **1.** Encourage legislators to draft legislation to promote prenatal care.

☐ **2.** Require all children to be immunized.
☐ **3.** Teach accident prevention and safety practices to children and their parents.
☐ **4.** Hire a nurse practitioner for each of the schools in the community.

128. A client has had an incisional cholecystectomy. Which of the following nursing interventions has the **highest** priority in postoperative care for this client?
☐ **1.** Using incentive spirometry every 2 hours while awake.
☐ **2.** Performing leg exercises every shift.
☐ **3.** Maintaining a weight reduction diet.
☐ **4.** Promoting incisional healing.

129. The nurse is evaluating an infant for auditory ability. Which of the following is the expected response in an infant with normal hearing?
☐ **1.** Blinking and stopping body movements when sound is introduced.
☐ **2.** Evidence of shy and withdrawn behaviors.
☐ **3.** Saying “da-da” by age 5 months.
☐ **4.** Absence of squealing by age 4 months.

130. A client who had a transurethral resection of the prostate (TURP) 1 day earlier has a three-way Foley catheter inserted for continuous bladder irrigation. Which of the following statements **best** explains why continuous irrigation is used after TURP?
☐ **1.** To control bleeding in the bladder.
☐ **2.** To instill antibiotics into the bladder.
☐ **3.** To keep the catheter free from clot obstruction.
☐ **4.** To prevent bladder distention.

131. Which of the following sounds should the nurse expect to hear when percussing a distended bladder?
☐ **1.** Hyperresonance.
☐ **2.** Tympany.
☐ **3.** Dullness.
☐ **4.** Flatness.

132. A tour bus has overturned on an exit ramp. Many passengers are injured, but there are no fatalities. While the emergency department nurse prepares for treating the injured, the nurse also calls the crisis nurse based on the understanding about which of the following?
☐ **1.** The accident victims will be experiencing grief and mourning.
☐ **2.** Many of the passengers may be experiencing feelings of victimization.
☐ **3.** There is a need for someone to coordinate calls from relatives about the

passengers.

☐ **4.** Some of the passengers will need psychiatric hospitalization.

133. A postoperative nursing goal for the infant who has had surgery to correct imperforate anus is to prevent tension on the perineum. To achieve this goal, the nurse should **not** place the neonate on the:

☐ **1.** Abdomen, with legs pulled up under the body.
☐ **2.** Back, with legs suspended at a 90-degree angle.
☐ **3.** Left side, with hips elevated.
☐ **4.** Right side, with hips elevated.

134. A child with meningococcal meningitis is being admitted to the pediatric unit. In preparation for the child's arrival, the nurse should **first**:

☐ **1.** Institute droplet precautions.
☐ **2.** Obtain the child's vital signs.
☐ **3.** Ask the parent about medication allergies.
☐ **4.** Inquire about the health of siblings at home.

135. When developing the plan of care for a 14-year-old boy who is bored due to being immobilized in a cast, which of the following activities is **most** appropriate?

☐ **1.** Playing a card game with a boy the same age.
☐ **2.** Putting together a puzzle with his mother.
☐ **3.** Playing video games with a 9-year-old.
☐ **4.** Watching a movie with his younger brother.

136. An adolescent is being prepared for an emergency appendectomy. What should the nurse tell the client? Select all that apply.

☐ **1.** Friends can visit whenever they want.
☐ **2.** The scar will be small.
☐ **3.** The teen will be back in school in 1 week.
☐ **4.** Antibiotics will be given to prevent an infection.
☐ **5.** A dressing will stay in place for 1 week.

137. A client receives morphine for postoperative pain. Which of the following assessments should the nurse include in the client's plan of care?

☐ **1.** Take apical heart rate after each dose of morphine.
☐ **2.** Assess urinary output every 8 hours.
☐ **3.** Assess mental status every shift.
☐ **4.** Check for pedal edema every 4 hours.

138. When infusing total parenteral nutrition (TPN), the nurse should assess the client for which of the following complications?

☐ **1.** Essential amino acid deficiency.
☐ **2.** Essential fatty acid deficiency.
☐ **3.** Hyperglycemia.
☐ **4.** Infection.

139. When assessing for signs of a blood transfusion reaction in a client with dark skin, the nurse should assess for which of the following?
☐ **1.** Hypertension.
☐ **2.** Diaphoresis.
☐ **3.** Polyuria.
☐ **4.** Warm skin.

140. The nurse is caring for a child with a head injury. Place the following assessments in order of priority, starting with the nursing assessment the nurse should perform **first**.

1. Vital signs.
2. Decreased urine output.
3. Level of consciousness.
4. Motor strength.

141. After surgery to create a urinary diversion, the client is at risk for a urinary tract infection. The nurse should plan to incorporate which of the following interventions into the client's care?
☐ **1.** Clamp the urinary appliance at night.
☐ **2.** Empty the urinary appliance when one-third full.
☐ **3.** Administer prophylactic antibiotics.
☐ **4.** Change the urinary appliance daily.

142. When suctioning a client's tracheostomy tube, the nurse should do which of the following?

☐ **1.** Oxygenate the client before suctioning.
☐ **2.** Insert the suction catheter about 2 inches (5.1 cm) into the cannula.
☐ **3.** Use a bolus of sterile water to stimulate cough.
☐ **4.** Use clean gloves during the procedure.

143. A 14-month-old child has a severe diaper rash. Which of the following recommendations should the nurse provide to the parents?

☐ **1.** Continue to use the baby wipes.
☐ **2.** Change the diaper every 4 to 6 hours.
☐ **3.** Wash the buttocks using mild soap.
☐ **4.** Apply powder to the diaper area.

144. On entering a toddler's room, the nurse finds the mother sitting about 8 feet (240 cm) from the child and watching television while the toddler is screaming. Which of the following is the **most** appropriate response by the nurse?

☐ **1.** “What happened between you and your child?”
☐ **2.** “Why is your child screaming?”
☐ **3.** “Did something cause your child to be upset?”
☐ **4.** “Have you tried to calm down your child?”

145. A client has a total hip replacement. Which of the following client statements indicates a need for further teaching before discharge?

☐ **1.** “I will implement my exercise program as soon as I get home.”
☐ **2.** “I will be careful not to cross my legs.”
☐ **3.** “I will need an elevated toilet seat.”
☐ **4.** “I can't wait to take a tub bath when I get home.”

146. An adolescent thinks she has infectious mononucleosis. The nurse should **next** assess the client for: Select all that apply.

☐ **1.** Sore throat.
☐ **2.** Malaise.
☐ **3.** Weight loss.
☐ **4.** Rash.
☐ **5.** Swollen lymph glands.

147. While assessing the fundus of a multiparous client on the first postpartum day, the nurse performs hand washing and puts on clean gloves. Which of the following should the nurse do **next**?

☐ **1.** Place the nondominant hand above the symphysis pubis and the dominant hand at the umbilicus.

☐ **2.** Ask the client to assume a side-lying position with the knees flexed.
☐ **3.** Perform massage vigorously at the level of the umbilicus if the fundus feels boggy.
☐ **4.** Place the client on a bedpan in case the uterine palpation stimulates the client to void.

148. A nulligravid client with gestational diabetes tells the nurse that she had a reactive nonstress test 3 days ago and asks, “What does that mean?” The nurse explains that a reactive nonstress test indicates which of the following about the fetus?
☐ **1.** Evidence of some compromise that will require childbirth soon.
☐ **3.** Fetal well-being at this point in the pregnancy.
☐ **3.** Evidence of late decelerations occurring during the test.
☐ **4.** No accelerations demonstrated within a 20-minute period.

149. A client has been diagnosed with right-sided heart failure. The nurse should assess the client further for:
☐ **1.** Intermittent claudication.
☐ **2.** Dyspnea.
☐ **3.** Dependent edema.
☐ **4.** Crackles.

150. To help prevent hip flexion deformities associated with rheumatoid arthritis, the nurse should help the client assume which of the following positions in bed several times a day?
☐ **1.** Prone.
☐ **2.** Very low Fowler's.
☐ **3.** Modified Trendelenburg.
☐ **4.** Side-lying.

151. Which of the following should be the nurse's priority assessment after an epidural anesthetic has been given to a nulligravid client in active labor?
☐ **1.** Level of consciousness.
☐ **2.** Blood pressure.
☐ **3.** Cognitive function.
☐ **4.** Contraction pattern.

152. Assessment of a nulligravid client in active labor reveals the following: moderate discomfort; cervix dilated 3 cm, 0 station, and completely effaced; and fetal heart rate of 136 bpm. Which of the following should the nurse plan to do **next**?
☐ **1.** Assist the client with comfort measures and breathing techniques.
☐ **2.** Turn the client from the left side-lying position to the right side-lying

position.

☐ **3.** Prepare the client for epidural anesthesia to relieve pain.

☐ **4.** Instruct the client that internal fetal monitoring is necessary.

153. The nurse monitors the serum electrolyte levels of a client who is taking digoxin (Lanoxin). Which of the following electrolyte imbalances is a common cause of digoxin toxicity?

☐ **1.** Hyponatremia.

☐ **2.** Hypomagnesemia.

☐ **3.** Hypocalcemia.

☐ **4.** Hypokalemia.

154. After abdominal surgery, a client has a prescription for meperidine (Demerol) IM 100 mg every 3 to 4 hours and acetaminophen (Tylenol) with codeine 30 mg. The client has been taking meperidine every 4 hours for the past 48 hours but tells the nurse that the meperidine is no longer lasting 4 hours and that the client needs to have it every 3 hours. Which of the following nursing actions is **most** appropriate?

☐ **1.** Realizing that the client is developing tolerance to the meperidine, the nurse administers the meperidine every 3 hours.

☐ **2.** The nurse urges the client to take the acetaminophen with codeine to prevent addiction to the meperidine.

☐ **3.** The nurse requests a prescription from the physician to change the dose to an equianalgesic dose of morphine.

☐ **4.** The nurse encourages the client to do relaxation exercises to provide distraction from the pain.

155. The nurse assesses a 7-month-old infant's growth and development. Which behavior should the nurse consider unusual?

☐ **1.** Drinking from a cup and spilling little of the liquid.

☐ **2.** Raising the chest and upper abdomen off the bed with the hands.

☐ **3.** Imitating sounds that the nurse makes.

☐ **4.** Crying loudly in protest when the mother leaves the room.

156. A 13-year-old client is dying of cancer. When providing care for this client, the nurse should incorporate the developmental tasks for this age. According to Erikson's developmental model, the child normally is expected to be working on which of the following psychosocial issues?

☐ **1.** Lifetime vocation.

☐ **2.** Social conscience.

☐ **3.** Personal values.

☐ **4.** Sense of competence.

157. The physician has prescribed amiodarone (Cordarone) for a client with cardiomyopathy. The nurse should monitor the client's electrocardiogram to determine the effectiveness of the medication in controlling:

☐ **1.** Sinus node dysfunction.
☐ **2.** Heart block.
☐ **3.** Severe bradycardia.
☐ **4.** Life-threatening ventricular dysrhythmias.

158. An 18-year-old female client who is sexually active with her boyfriend has a purulent vaginal discharge that is sometimes frothy. The nurse interprets this as suggesting which of the following?

☐ **1.** Sexually transmitted disease.
☐ **2.** Normal variations in vaginal discharge.
☐ **3.** Need for vaginal douching.
☐ **4.** Change in birth control method.

159. An elderly client has been bedridden since a cerebrovascular accident that resulted in total right-sided paralysis. The client has become increasingly confused, is occasionally incontinent of urine, and is refusing to eat. In planning the client's care, which of the following factors should the nurse consider as most critical in contributing to skin breakdown in this client?

☐ **1.** Nutritional status.
☐ **2.** Urinary incontinence.
☐ **3.** Episodes of confusion.
☐ **4.** Right-sided paralysis.

160. Assessment of a client who has just been admitted to the inpatient psychiatric unit reveals an unshaven face, noticeable body odor, visible spots on the shirt and pants, slow movements, gazing at the floor, and a flat affect. Which of the following should the nurse interpret as indicating psychomotor retardation?

☐ **1.** Slow movements.
☐ **2.** Flat affect.
☐ **3.** Unkempt appearance.
☐ **4.** Avoidance of eye contact.

161. A nurse notices that a newborn has a swelling in the scrotal area. The nurse interprets this swelling as indicative of hydrocele if which of the following occurs?

☐ **1.** The swollen bulge can be reduced.
☐ **2.** The increase in scrotal size is bilateral.
☐ **3.** The scrotal sac can be transilluminated.

☐ **4.** The bulge appears during crying.

162. When cleaning the skin around an incision and drain site, which of the following procedures should the nurse follow?

☐ **1.** Clean the incision and drain site separately.
☐ **2.** Clean from the incision to the drain site.
☐ **3.** Clean from the drain site to the incision.
☐ **4.** Clean the incision and drain site simultaneously.

163. A woman who speaks Spanish only and is very upset brings her child to the clinic with bleeding from the mouth. Which of the following is the **most** appropriate action by the nurse who does not speak Spanish?

☐ **1.** Call for the Spanish interpreter.
☐ **2.** Grab the child and take the child to the treatment room.
☐ **3.** Immediately apply ice to the child's mouth.
☐ **4.** Give the ice to the mother and demonstrate what to do.

164. The nurse is instructing a nursing assistant on the prevention of postoperative pulmonary complications. Which of the following statements indicates that the assistant has understood the nurse's instructions?

☐ **1.** “I will turn the client every 4 hours.”
☐ **2.** “I will keep the client's head elevated.”
☐ **3.** “I should suction the client every 2 hours.”
☐ **4.** “I will have the client take 5 to 10 deep breaths every hour.”

165. Which of the following outcomes is desired when a client with arterial insufficiency has poor tissue perfusion in the extremities? Select all that apply.

☐ **1.** Extremities warm to touch.
☐ **2.** Improved respiratory status.
☐ **3.** Decreased muscle pain with activity.
☐ **4.** Participation in self-care measures.
☐ **5.** Lungs clear to auscultation.

166. The infusion rate of total parenteral nutrition (TPN) is tapered before being discontinued. This is done to prevent which of the following complications?

☐ **1.** Essential fatty acid deficiency.
☐ **2.** Dehydration.
☐ **3.** Rebound hypoglycemia.
☐ **4.** Malnutrition.

167. While assessing the psychosocial aspects of a primigravid client at 30 weeks' gestation, which of the following feelings are expected?

☐ **1.** Vulnerability.
☐ **2.** Confirmation.
☐ **3.** Ambivalence.
☐ **4.** Body image disturbance.

168. The nurse teaches a client scheduled for an IV pyelogram what to expect when the dye is injected. The client has correctly understood what was taught when the client states that there may be which of the following sensations when the dye is injected?
☐ **1.** A metallic taste.
☐ **2.** Flushing of the face.
☐ **3.** Cold chills.
☐ **4.** Chest pain.

169. To prevent development of peripheral neuropathies associated with isoniazid administration, the nurse should teach the client to:
☐ **1.** Avoid excessive sun exposure.
☐ **2.** Follow a low-cholesterol diet.
☐ **3.** Obtain extra rest.
☐ **4.** Supplement the diet with pyridoxine (vitamin B_6).

170. A usually reliable interpreter called by the nurse to help communicate with a mother of a child who does not speak English and has brought her child in for a routine visit has yet to arrive in the clinic. The nurse has paged the interpreter several times. Which of the following should the nurse do **next**?
☐ **1.** Continue with the examination.
☐ **2.** Reschedule the infant's appointment for later in the week.
☐ **3.** Ask the mother to stay longer in the hope that the interpreter arrives.
☐ **4.** Page the interpreter one more time.

171. Before discharge from the hospital after a myocardial infarction, a client is taught to exercise by gradually increasing the distance walked. Which vital sign should the nurse teach the client to monitor to determine whether to increase or decrease the exercise level?
☐ **1.** Pulse rate.
☐ **2.** Blood pressure.
☐ **3.** Body temperature.
☐ **4.** Respiratory rate.

172. During an appointment with the nurse, a client says, “I could hate God for that flood.” The nurse responds, “Oh, don't feel that way. We're making progress in these sessions.” The nurse's statement demonstrates a failure to do

which of the following?

☐ **1.** Look for meaning in what the client says.
☐ **2.** Explain to the client why he may think as he does.
☐ **3.** Add to the strength of the client's support system.
☐ **4.** Give the client credit for solving his own problems.

173. The nurse has just received the change of shift report on the following clients on the labor, birth, recovery, and postpartum unit. Which of these clients should the nurse assess **first**?

☐ **1.** An 18-year-old single primigravid client, in labor for 9 hours, with cervical dilation at 6 cm, 0 station, contractions occurring every 5 minutes, and receiving epidural anesthesia.
☐ **2.** A 24-year-old primiparous client who gave vaginal birth to a 7-lb, 3-oz (3,260-g) boy 1 hour ago, has a firm fundus and scant lochia rubra, and is attempting to breast-feed.
☐ **3.** A 26-year-old multigravid client, in labor for 8 hours, with cervical dilation at 8 cm, 1+ station, contractions every 3 to 4 minutes, and receiving no anesthesia.
☐ **4.** A 30-year-old multipara who gave birth to a 6-lb, 5-oz (2,863-g) girl by cesarean owing to fetal distress 3 hours ago, has a firm fundus and scant lochia rubra, and is receiving morphine by patient-controlled analgesia.

174. A client with type 1 diabetes mellitus is scheduled to have surgery. The client has been nothing-by-mouth (NPO) since midnight. In the morning, the nurse notices that the client's daily insulin has not been prescribed. Which action should the nurse do **first**?

☐ **3.** Obtain the client's blood glucose level at the bedside.
☐ **2.** Contact the physician for further prescriptions regarding insulin dosage.
☐ **3.** Give the client's usual morning dose of insulin.
☐ **4.** Inform the Post Anesthesia Care Unit (PACU) staff to obtain the insulin prescription.

175. A client's chest tube is to be removed by the physician. Which of the following items should the nurse have ready to be placed directly over the wound when the chest tube is removed?

☐ **1.** Butterfly dressing.
☐ **2.** Montgomery strap.
☐ **3.** Fine mesh gauze dressing.
☐ **4.** Petrolatum gauze dressing.

176. The nurse observes that the client with multiple sclerosis looks untidy and sad. The client suddenly says, “I can't even find the strength to comb my

hair," and bursts into tears. Which of the following responses by the nurse is **best**?

☐ **1.** "It must be frustrating not to be able to care for yourself."
☐ **2.** "How many days have you been unable to comb your hair?"
☐ **3.** "Why hasn't your husband been helping you?"
☐ **4.** "Tell me more about how you're feeling."

177. A client newly diagnosed with bulimia is attending a nurse-led group at the mental health center. She tells the group that she only came because her husband said he would divorce her if she didn't get help. Which of the following responses by the nurse is **most** appropriate?

☐ **1.** "You sound angry with your husband. Is that correct?"
☐ **2.** "You will find that you like coming to group. These people are a lot of fun."
☐ **3.** "Tell me more about why you are here and how you feel about that."
☐ **4.** "Tell me something about what has caused you to be bulimic."

178. A diabetic client has been diagnosed with hypertension, and the physician has prescribed atenolol (Tenormin), a beta-blocker. When performing discharge teaching, it is important for the client to recognize that the addition of Tenormin can cause:

☐ **1.** A decrease in the hypoglycemic effects of insulin.
☐ **3.** An increase in the hypoglycemic effects of insulin.
☐ **3.** An increase in the incidence of ketoacidosis.
☐ **4.** A decrease in the incidence of ketoacidosis.

179. The parent of a child who is taking an antibiotic for bilateral otitis media tells the nurse that they have stopped the medicine since the child is better and are saving the rest of the medication to use the next time the child gets sick. Which of the following is the nurse's **best** response?

☐ **1.** "It is important to give the medicine as prescribed."
☐ **2.** "How do you know your child's ears are cured?"
☐ **3.** "Your child needs all of the medicine so that the infection clears."
☐ **4.** "Stopping the medicine is not what's best for your child!"

180. The nurse is making rounds and observes a client who is unconscious (see figure). The nursing assistant has just turned the client from lying on her back. Before raising the side rail, the nurse should:

☐ **1.** Elevate the head of the bed to 30 degrees.
☐ **2.** Ask the nursing assistant to add a pillow under the right arm.
☐ **3.** Inspect the skin at pressure points from the back-lying position.
☐ **4.** Help the nursing assistant move the client closer to the head of the bed.

181. The nurse is preparing a teaching plan for a client who is being discharged after being admitted for chest pain. The client has had one previous myocardial infarction 2 years ago and has been taking simvastatin 40 mg for the last 2 years. After reviewing the lab results for the client's cholesterol levels (see chart below), the nurse should:

lab report

Test	Result	Units	Reference Range
Cholesterol total	200	mg/dL	<200
Triglycerides	106	mg/dL	<150
HDL-cholesterol	69	mg/dL	>39

☐ **1.** Ask if the client is taking the simvastatin regularly.
☐ **2.** Tell the client that the cholesterol levels are within normal limits.
☐ **3.** Instruct the client to lower the saturated fat in the diet.
☐ **4.** Review the chart for lab reports of hemoglobin and hematocrit.

182. Sodium polystyrene sulfonate (Kayexalate) is prescribed for a client following crush injury. The drug is effective if:
☐ **1.** The pulse is weak and irregular.
☐ **2.** The serum potassium is 4.0 mEq/L (4.0 mmol/L).

☐ **3.** The ECG is showing tall, peaked T waves.
☐ **4.** There is muscle weakness on physical examination.

183. The nurse is teaching a young female about using oxcarbazepine (Trileptal) to control seizures. The nurse determines teaching is effective when the client states:
☐ **1.** "I will use one of the barrier methods of contraception."
☐ **2.** "I will need a higher dose of oral contraceptive when on this drug."
☐ **3.** "Since I am 28 years old, I should not delay starting a family."
☐ **4.** "I must weigh myself weekly to check for sudden gain in weight."

184. A client diagnosed with chronic renal failure is undergoing hemodialysis. Postdialysis, the client weighs 59 kg. The nurse should teach the client to:
☐ **1.** Increase the amount of sodium in the diet to 4 g/day.
☐ **2.** Limit the total amount of calories consumed each day to 1,000.
☐ **3.** Increase fluid intake to 3,000 mL each day.
☐ **4.** Control the amount of protein intake to 59 to 70 g/day.

185. An elderly client admitted with new-onset confusion, headache, and bounding pulse has been drinking copious amounts of water and voiding frequently. The nurse reviews the lab results (see chart). Which of the abnormal lab values is consistent with the client's symptoms?

Lab Values

	Result	Reference Range
Serum osmolality	325 mmol/kg H_2O	(275–295 mmol/kg H_2O)
Platelet count	122	(150–400 × 10^9/L)
Serum sodium	122 mmol/L	(135–145 mmol/L)
Urine specific gravity	1.041	(1.003–1.035)

☐ **1.** Serum osmolality.
☐ **2.** Platelet count.
☐ **3.** Serum sodium.
☐ **4.** Urine specific gravity.

186. A term primigravida was involved in a car accident 3 hours ago. She is having labor contractions every 4 minutes and her cervix is 3/100/-1. She is crying uncontrollably and states her pain is constant and severe rating it at 10/10. The priority action by the nurse is to:

☐ **1.** Reassure the woman and assist with nonpharmacologic pain interventions.
☐ **2.** Assess intensity of contractions and determine if she would like an epidural.
☐ **3.** Notify the provider of the pain and request an assessment for potential abruption.
☐ **4.** Perform a vaginal exam and coach the woman with breathing exercise for pain control.

187. A school nurse interviews the parent of a middle school student, who is exhibiting behavioral problems, including substance abuse, following a sibling's suicide. The parent says, “I am a single parent who has to work hard to support my family and now, I've lost my only son and my daughter is acting out and making me crazy! I just can't take all this stress!” Which of the following issues is the **priority**?

☐ **1.** Parent's ability to emotionally support the adolescent in this crisis.
☐ **2.** Potential suicidal thoughts/plans of both family members.
☐ **3.** The adolescent's anger.
☐ **4.** The parent's frustration.

188. When creating an educational program about safety, what information should the nurse include about sexual predators? Select all that apply.

☐ **1.** Child molesters pick children or teens over which they have some authority, making it easier for them to manipulate the child with special favors or attention.
☐ **2.** Child molesters resort to molestation because they have bad childhoods, so understanding that can help them decrease their molesting.
☐ **3.** Child molesters gain the child's trust before making sexual advances so the child feels obligated to comply with sex.
☐ **4.** Child molesters often choose children whose parents must work long hours, making the extra attention initially welcomed by the child.
☐ **5.** Child molesters maintain the secrecy of their actions by making threats if offering attention and favors fail or if the child is close to revealing the secret.

189. Sequential compression therapy is to be used postoperatively on the client's legs. The nurse must take which of the following actions first when the client returns to the room?

☐ **1.** Confirm the client's identity using two client identifiers.
☐ **2.** Wash hands.
☐ **3.** Explain the sequential compression therapy to the client.
☐ **4.** Determine the size of sleeve that is needed.

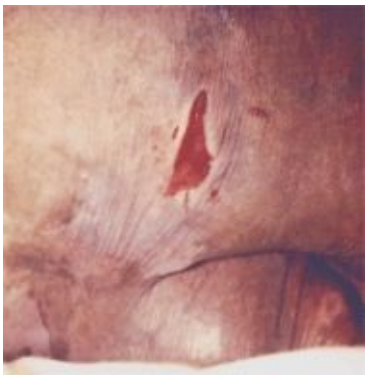
The nurse is caring for a previously healthy, independent 28-year-old client who is alert and oriented and is being admitted to the hospital for unexplained vomiting and abdominal pain. The client has intravenous fluids infusing through a saline lock and has been ambulating in the hallway with a steady gait. Using the Morse Fall Risk Scale (see chart), what is this client's total score and risk level?

Morse Fall Risk/Scale

Item	Scale	Scoring
1. History of falling, immediate or within 3 months	No 0 Yes 25	
2. Secondary diagnosis	No 0 Yes 15	
3. Ambulatory aid Bed rest/nurse assist Crutches/cane/walker Furniture	 0 15 30	
4. IV/heparin Lock	No 0 Yes 20	
5. Gait/transferring Normal/bed rest/ immobile Weak Impaired	 0 10 20	
6. Mental status Oriented to own ability Forgets limitations	 0 15	

Score _____ Risk _____.

191. The nurse is planning care for an 80-year-old client with a pressure ulcer (see figure). The nurse should do which of the following? Select all that apply.



☐ **1.** Elevate the head of the bed to 50 degrees.
☐ **2.** Obtain daily cultures.
☐ **3.** Cover with protective dressing.
☐ **4.** Reposition the client every 2 hours.
☐ **5.** Request an alternating-pressure mattress.

Answers, Rationales, and Test-Taking Strategies

The answers and rationales for each question follow below, along with keys ( *) to the client need (CN) and cognitive level (CL) for each question. As you check your answers, use the* ***Content Mastery and Test-Taking Skill Self-Analysis*** *worksheet (tear-out worksheet in back of book) to identify the reason(s) for not answering the questions correctly. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21 and pages 31–32 in Part 1 of this book.*

1. 2. The nurse is responsible for maintaining confidentiality of this disclosure by the client.

 CN: Psychosocial integrity; CL: Synthesize

2. 2. Pets are discouraged when parents are trying to allergy-proof a home for a child with bronchial asthma, unless the pets are kept outside. Pets with hair or feathers are especially likely to trigger asthma attacks. A fish is a satisfactory pet for this child, but the parents should be taught to keep the fish tank clean to prevent it from harboring mold.

 CN: Health promotion and maintenance; CL: Synthesize

3. 2. Under the policy for valuables, the nurse documents the description on an envelope with the client, the client and nurse sign the envelope, and the valuables envelope is locked in the safe. The other options increase the risk of loss or damage to the client's valuables.

 CN: Management of care; CL: Synthesize

4. 1. Sucking provides the infant with a sense of security and comfort. It also is an outlet for releasing tension. The infant should not be discouraged from sucking on the pacifier. Fussiness after feeding may indicate that the infant's appetite is not satisfied. Sucking is not manipulative in the sense of seeking parental attention.

 CN: Health promotion and maintenance; CL: Analyze

5. 3. Sexually transmitted diseases are communicable diseases that must be reported. The nurse is responsible for reporting these diseases to the appropriate public health agency and to otherwise maintain the client's confidentiality. The

client's family cannot request release of medical information without the client's consent. A physician's prescription is not a substitute for a client's consent to release medical information in the absence of a communicable disease.

 CN: Management of care; CL: Synthesize

6. 4. In a life-threatening emergency where time is of the essence in saving life or limb, consent is not required. This client has a Glasgow Coma Scale score of 7, which indicates a comatose state. The client cannot be aroused, withdraws in a purposeless manner from painful stimuli, exhibits decorticate posturing, and may or may not have brain stem reflexes intact. The placement of the ICP monitor is crucial to determine cerebral blood flow and prevent herniation. The client's fiancée cannot sign the consent because, until she is his wife or has designated power of attorney, she is not considered his next of kin. The physician should insert the catheter in this emergency. He does not need to get a consultation from another physician. When consent is needed for a situation that is not a true emergency, two nurses can receive a verbal consent by telephone from the client's next of kin.

 CN: Management of care; CL: Apply

7. 4. Follow-up generally involves semiannual chest radiographs. Recurrence usually occurs locally in the lungs and may be identified on chest radiographs. Follow-up after cancer treatment is an important component of the treatment plan. Serum markers (liver function tests) have not been shown to detect recurrence of lung cancer. There are no data to support the need for an abdominal computed tomography scan.

 CN: Reduction of risk potential; CL: Synthesize

8. 1. All blood products should be administered through a micron mesh filter. Blood is never administered without a filter. Leukocytes can be removed by using leukocyte-poor filters, and this is recommended to decrease reactions in clients, such as hemophiliacs, who require frequent transfusions. Blood is too concentrated to administer through a microdrip set.

 CN: Pharmacological and parenteral therapies; CL: Apply

9. 3. One of the best strategies to help clients feel in control is to ask them their view of situations and to respond to what they say. This technique acknowledges that clients' opinions have value and relevance to the interview. It also promotes an active role for clients in the process. Use of a questionnaire or written instructions is a means of obtaining information but promotes a passive client role. Asking whether clients have questions encourages participation, but

alone it does not acknowledge their views.

CN: Management of care; CL: Synthesize

10. 2, 3, 4, 5. Socialization and communication, in addition to increased activity, are all means to aid in prevention of self-injury. Education of family members may foster development of strategies to prevent self-injury; hence, mitten restraints could be avoided. Applying lotion after bathing may not be appropriate when the skin is broken and not intact.

CN: Management of care; CL: Synthesize

11. 3. A client with severe depression may experience symptoms of psychosis such as hallucinations and delusions that are typically mood congruent. The statement, “My heart has stopped and my blood is black ash,” is a mood-congruent somatic delusion. A delusion is a firm, false, fixed belief that is resistant to reason or fact. A hallucination is a false sensory perception unrelated to external stimuli. An illusion is a misinterpretation of a real sensory stimulus. Paranoia refers to suspiciousness of others and their actions.

CN: Psychosocial integrity; CL: Analyze

12. 2. The client should be allowed to see the chart. As a client advocate, the nurse should answer questions for the client. The nurse helps the client become a primary partner in the health team. The Bill of Rights for Patients has existed since the 1960s, and every client should be aware of this document. The doctor should not need to give permission for the client to see the chart. As a client advocate, the nurse should not make excuses to put the client off in regard to seeing the chart.

CN: Management of care; CL: Apply

13. 3. The three-point gait, in which the client advances the crutches and the affected leg at the same time while weight is supported on the unaffected extremity, is the appropriate gait of choice. This allows for non–weight bearing on the affected extremity. The two-point, four-point, and swing-to gaits require some weight bearing on both legs, which is contraindicated for this client.

CN: Reduction of risk potential; CL: Evaluate

14. 1. When the client verbalizes that life isn't worth living anymore, the nurse needs to ask the client directly about suicide by saying, “Are you thinking about killing yourself?” Asking directly does not provoke suicide but conveys concern, understanding, and the worth of the client. Commonly, the client experiences a sense of relief that someone finally hears him. It also helps the nurse plan responsible care by identifying the client who is at risk for suicide.

The nurse should then evaluate the seriousness of the suicidal ideation by inquiring about the intent and plan. Stating, “Things will get better,” offers hope too soon without first evaluating the intent of the suicidal ideation. Asking, “Why do you think that way?” implies a lack of understanding and knowledge on the part of the nurse. Major depression usually is endogenous and biochemically based. Therefore, the client may not know why he doesn't want to live. Saying, “You shouldn't feel that way,” admonishes the client, decreases self-worth, and conveys a lack of understanding.

CN: Psychosocial integrity; CL: Synthesize

15. 1, 4, 5. Lamotrigine, an antiepileptic, is used as a mood stabilizer for clients with bipolar disorder and has been found to be effective for the depressive phase of bipolar disorder. Common adverse effects are dizziness, headache, sedation, tremors, nausea, vomiting, and ataxia. The development of a rash needs to be reported and evaluated by the physician because it could indicate the start of a severe systemic rash known as Stevens-Johnson syndrome, a toxic epidermal necrolysis, which would necessitate the discontinuation of lamotrigine. Hyperthermia in conjunction with muscle rigidity suggests the development of neuroleptic malignant syndrome, a life-threatening complication associated with olanzapine.

CN: Pharmacological and parenteral therapies; CL: Analyze

16. 0.8 mL

$$\frac{0.4\text{ mg}}{X} = \frac{0.5\text{ mg}}{1\text{ mL}}$$

$$0.4 = 0.5X$$

$$\frac{0.4}{0.5} = X$$

$$0.8\text{ mL} = X.$$

CN: Pharmacological and parenteral therapies; CL: Apply

17. 4. The nurse should instruct the client to increase her intake of calcium because there is a slight increase in the risk of osteoporosis with this medication. Weight-bearing exercises are also advised. The drug may also impair glucose tolerance in women who are at risk for diabetes.

CN: Pharmacological and parenteral therapies; CL: Synthesize

18. 1, 2, 5. The first trimester is when the couple works through the psychological task of accepting the pregnancy. These statements describe the client and her partner coping with the pregnancy, how it feels, and how it will

impact their lives. The feelings include pleasure, excitement, and ambivalence. Wondering what the baby will look like and planning for the baby's room occur later in the pregnancy.

 CN: Health promotion and maintenance; CL: Analyze

19. 4. The aminoglycoside antibiotic gentamicin sulfate should not be applied to large denuded areas because toxicity and systemic absorption are possible. The nurse should instruct the client to avoid excessive sun exposure because gentamicin sulfate can cause photosensitivity. The client should be instructed to apply the cream or ointment for only the length of time prescribed because a superinfection can occur from overuse. The client should contact the physician if the condition worsens after use.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

20. 2, 5, 6. HCTZ is a thiazide diuretic used in the management of mild to moderate hypertension and in the treatment of edema associated with heart failure, renal dysfunction, cirrhosis, corticosteroid therapy, and estrogen therapy. It increases the excretion of sodium and water by inhibiting sodium reabsorption in the distal tubule of the kidneys. It promotes the excretion of chloride, potassium, magnesium, and bicarbonate. Side effects include drowsiness, lethargy, and muscle weakness but not muscle twitching. Although there may be abdominal cramping, there is no diarrhea. The client does not become confused as a result of taking this drug.

 CN: Health promotion and maintenance; CL: Analyze

21. 3. The nurse needs to inform the sister that it takes 2 to 4 weeks before a full clinical effect occurs with the drug. The nurse should let her know that her brother will gradually get better and symptoms of depression will improve. Telling the sister that her brother is experiencing a very serious depression does not give the sister important information about the medication. Additionally, this statement may cause alarm and anxiety. Conveying the sister's concern to the physician does not provide her with the necessary information about the client's medication. Telling the sister that the client's medication may need to be changed is inappropriate because a full clinical effect occurs after 2 to 4 weeks.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

22. 1, 2, 3. For the client with grandiose delusions, the nurse should accept the client but not argue with the delusion to build trust and the client's self-esteem. Focusing on the underlying feeling or meaning of the delusion helps to meet the client's needs. Focusing on events and topics based in reality distracts

the client from the delusional thinking. Confronting the client's delusions or beliefs can lead to agitation in the client and the need to cling to the grandiose delusion to preserve self-esteem. Interacting with the client only when based in reality ignores the client's needs and therapeutic nursing intervention.

 CN: Psychosocial integrity; CL: Synthesize

23. 1. Saying, “When you interrupt others, they leave the area,” is most helpful because it serves to increase the client's awareness of others' perceptions of the behavior by giving specific feedback about the behavior. The other statements are punitive and authoritative, possibly threatening to the client, and likely to increase defensiveness, decrease self-worth, and increase feelings of guilt.

 CN: Psychosocial integrity; CL: Synthesize

24. 4. To determine how low the gentamicin serum level drops between doses, the trough serum level should be drawn just before the administration of the next IV dose of gentamicin sulfate.

 CN: Pharmacological and parenteral therapies; CL: Apply

25. 2. Chest pain and dyspnea are signs of a pneumothorax and should be treated immediately. Delayed puberty is common in adolescents with CF and is caused by poor nutrition. Poor weight gain is common in children with CF because so little is absorbed in the small intestine. Large, foul-smelling stools indicate noncompliance with taking enzymes and should be addressed, but respiratory complications are the greatest concern.

 CN: Physiological adaptation; CL: Analyze

26. 3. The child is exhibiting signs and symptoms of possible epiglottiditis. As a result, the child is at high risk for laryngospasm and airway occlusion. Therefore, the nurse should have a tracheostomy tube and setup readily available should the child experience an airway occlusion. Although acetaminophen is an antipyretic, the dosage of 600 mg to be administered rectally is too high. A typical 4-year-old weighs approximately 40 lb (18.1 kg). The recommended dose is 125 mg. When any type of respiratory illness, and especially epiglottiditis, is suspected, putting any object, including a tongue depressor for inspection or a cotton-tipped applicator to obtain a throat culture, in the back of the mouth or throat or having the child open the mouth is inappropriate because doing so may predispose the child to laryngospasm or occlusion of the airway by a swollen epiglottis.

 CN: Reduction of risk potential; CL: Synthesize

27. 3. The client is exhibiting temporary side effects associated with lithium therapy. Therefore, the nurse should continue the lithium and explain to the client that the temporary side effects of lithium that will subside. Common side effects of lithium are nausea, dry mouth, diarrhea, thirst, mild hand tremor, weight gain, bloating, insomnia, and light-headedness. Immediately notifying the physician about these common side effects is not necessary.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

28. 1. Thyroid replacement is a lifelong maintenance therapy. The medication is usually given as one dose in the morning. It cannot be tapered or discontinued because the client needs thyroid supplementation to maintain health. The medication cannot be discontinued after the TSH level is normal; the dose will be maintained at the level that normalizes the TSH concentration.

 CN: Pharmacological and parenteral therapies; CL: Apply

29. 4. A client who is beginning training for a tennis team would most likely require an adjustment in lithium dosage because excessive sweating can increase the serum lithium level, possibly leading to toxicity. Adjustments in lithium dosage would also be necessary when other medications have been added, when an illness with high fever occurs, and when a new diet begins.

 CN: Pharmacological and parenteral therapies; CL: Analyze

30. 4. Traveling is usually discouraged if preterm labor has been a problem, as it restricts normal movement. A client should be able to walk around frequently to prevent blood clots and to empty her bladder at least every 1 to 2 hours. Bladder infections often stimulate preterm labor and preventing them is of great importance to this client. Contractions that recur indicate the return of preterm labor, and the health care provider needs to be notified. Dehydration is known to stimulate preterm labor and encouraging the client to drink adequate amounts of water helps to prevent this problem.

 CN: Reduction of risk potential; CL: Evaluate

31. 3. The most appropriate response is to continue all treatments and attempt to stabilize the client using fluid replacement without administering blood or blood products. It is imperative that the health care team respect the client's religious beliefs and wishes, even if they are not those of the health care team. Discontinuing all measures is not an option. The health care team should continue to provide the best care possible and does not need to notify the attorney.

 CN: Management of care; CL: Synthesize

32. 2. Cystic fibrosis is the most common inherited disease in children. It is inherited as an autosomal recessive trait, meaning that the child inherits the defective gene from both parents. The chances are one in four for each of this couple's pregnancies.

 CN: Reduction of risk potential; CL: Apply

33. 3. Nitroglycerin in all dosage forms (sublingual, transdermal, or intravenous) should be shielded from light to prevent deterioration. The client should be instructed to keep the nitroglycerin in the dark container that is supplied by the pharmacy, and it should not be removed or placed in another container.

 CN: Pharmacological and parenteral therapies; CL: Apply

34. 3. Valproic acid causes sedation as well as nausea, vomiting, and indigestion. Sedation is important because the client needs to be cautioned about driving or operating machinery that could be dangerous while feeling sedated from the medication. Valproic acid does not cause increased urination, slowed thinking, or weight loss. However, some clients may experience weight gain.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

35. 1. These effects and others when seen after birth are known as a cluster of symptoms called fetal alcohol syndrome. Vitamin B_6 and vitamin A deficiency can affect growth and development but not with these specific effects. Folic acid deficiency contributes to neural tube defects.

 CN: Reduction of risk potential; CL: Analyze

36. 4. NSAIDs irritate the gastric mucosa and should be taken with food. NSAIDs are usually taken once or twice daily. Joint exercise is not related to the drug administration. Antacids may interfere with the absorption of NSAIDs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

37. 2. The client who drinks alcohol while taking disulfiram experiences sweating, flushing of the neck and face, tachycardia, hypotension, a throbbing headache, nausea and vomiting, palpitations, dyspnea, tremor, and weakness.

 CN: Pharmacological and parenteral therapies; CL: Analyze

38. 3. Holding the gauze pledget against an IM injection site while removing the needle from the muscle avoids the discomfort of the needle pulling on the skin.

 CN: Pharmacological and parenteral therapies; CL: Apply

39. 3. Physical activity is gradually increased after a myocardial infarction

while the client is still hospitalized and through a period of rehabilitation. The client is progressing too rapidly if activity significantly changes respirations, causing dyspnea, chest pain, a rapid heartbeat, or fatigue. When any of these symptoms appears, the client should reduce activity and progress more slowly. Edema suggests a circulatory problem that must be addressed but doesn't necessarily indicate overexertion. Cyanosis indicates reduced oxygen-carrying capacity of red blood cells and indicates a severe pathology. It is not appropriate to use cyanosis as an indicator for overexertion. Weight loss indicates several factors but not overexertion.

 CN: Reduction of risk potential; CL: Analyze

40. 1, 2, 4. Telehealth is becoming an increasingly available way for nurses to conduct counseling sessions with clients who are at a distance from a health care provider or health care facility. The client saves travel time and can avoid precipitating symptoms associated with the stress disorder that might occur as a result of a visit to a health care facility. The client also can access care that might not otherwise be easily available. Treatment for PSTD is long-term, and there is no evidence to suggest that telehealth versus face-to-face counseling shortens recovery time. Counseling sessions using telehealth technology are conducted on an individual basis between one client and a health care provider, but group support may be available if required as a part of a treatment plan.

 CN: Management of care; CL: Evaluate

41. 3. When a client talks about not having a problem with alcohol, the nurse needs to point out how alcohol has gotten the client into trouble. Concrete facts are helpful in decreasing the client's denial that alcohol is a problem. The other approaches allow the client to use defense mechanisms, such as rationalization, projection, and minimization, to explain her actions. Therefore, these approaches are not helpful.

 CN: Psychosocial integrity; CL: Synthesize

42.

1. Gloves

3. Gown

2. Goggles

4. Mask

The nurse should remove the dirtiest items first. This typically is the gloves followed by the gown. It is then recommend that the nurse perform hand hygiene and remove the goggles, which may fit over the mask. Finally, the mask is removed from behind. The nurse should then again perform hand hygiene when all PPE has been removed.

CN: Safety and infection control; CL: Apply

43. 3. Before development and implementation of the teaching plan, it is vital to determine what the client currently knows regarding diabetes and what the client needs to know.

CN: Management of care; CL: Create

44. 1. The goal of the education program is to instruct the client to take the pulse; therefore, the expected outcome would be the ability to give a return demonstration of how to palpate the heart rate.

CN: Reduction of risk potential; CL: Evaluate

45. 3. Percutaneous umbilical blood sampling is a useful procedure for diagnosing Rh disease, obtaining fetal complete blood count, and karyotyping chromosomes to evaluate for genetic disorders. Ultrasound commonly is used to detect twins. A lecithin-sphingomyelin ratio is the procedure of choice to diagnose fetal lung maturation. A maternal blood test is used to determine the alpha fetoprotein level.

CN: Reduction of risk potential; CL: Apply

46. 2. The client should report tinnitus because vancomycin can affect the acoustic branch of the eighth cranial nerve. Vancomycin does not affect the vestibular branch of the acoustic nerve; vertigo and ataxia would occur if the vestibular branch were involved. Muscle stiffness is not associated with vancomycin.

CN: Pharmacological and parenteral therapies; CL: Analyze

47. 4. Caffeinated beverages and alcohol should be avoided because they stimulate gastric acid production and irritate gastric mucosa. The client should avoid foods that cause discomfort; however, there is no need to follow a soft, bland diet. Eating six small meals daily is no longer a common treatment for peptic ulcer disease. Milk in large quantities is not recommended because it actually stimulates further production of gastric acid.

CN: Reduction of risk potential; CL: Evaluate

48. 3. When a client with a NG tube exhibits abdominal distention, the nurse should first check the suction machine. If the suction equipment is functioning properly, then the nurse should take other steps, such as repositioning the tube or checking tube patency by irrigating it. If these steps are not effective, then the physician should be called.

CN: Reduction of risk potential; CL: Synthesize

49. 4. Increased, not decreased, body temperature resulting from occupations or infections can contribute to low sperm counts caused by decreased sperm production. Heat can destroy sperm. Varicocele, an abnormal dilation of the veins in the spermatic cord, is an associated cause of a low sperm count. The varicosity increases the temperature within the testes, inhibiting sperm production. Frequent use of saunas or hot tubs may lead to a low sperm count. The temperature of the scrotum becomes elevated, possibly inhibiting sperm production. Endocrine imbalances (thyroid problems) are associated with low sperm counts in men because of possible interference with spermatogenesis.

CN: Reduction of risk potential; CL: Evaluate

50.

4. The client from the emergency department at term and screaming loudly because of labor contractions.
2. The client with right lower quadrant pain at 10 weeks' gestation.
1. The client with clear vesicles and brown vaginal discharge at 16 weeks' gestation.
3. The client who is at term and has had no fetal movement for 2 days.

First, the nurse should assess the client from the emergency department who is screaming because she may be anywhere along the labor continuum and her status will be unknown until she has a vaginal exam to determine cervical effacement and dilation. The nurse should next assess the client with right lower quadrant pain as she may be experiencing an ectopic pregnancy or appendicitis

and may need further evaluation by the health care provider. The client with clear vesicles and brown vaginal discharge is experiencing a molar pregnancy and will need to have a D&C to evacuate the vesicles; this condition will not jeopardize the life of the mother if no intervention occurs within an hour. The client who is at term without fetal movement is a priority from an emotional standpoint if there is no heart beat when she is evaluated, but the physical status of the fetus with no fetal movement for 2 days will not change if not seen within the next 1/2 hour and the nurse can see this client last. The emotional care for this client will be extensive if there is a diagnosis of fetal demise, and the nurse should plan the time to be available to support this client as needed.

 CN: Management of care; CL: Synthesize

51. 1, 3, 4, 5. Talking with other staff and his personal support system help diminish fears and anger about being injured. It is appropriate to facilitate the injured staff member's return to work to decrease the chance of resignation or difficulties in performing duties. Talking with the assaultive client can be helpful if the client is apologetic but is not required. Legal action against a client is controversial and not always appropriate depending on the client's illness.

 CN: Management of Care; CL: Evaluate

52. 1, 2, 3, 5. Acknowledging the client's concern about pain and expressing the nurse's concern about the client's condition are important to help the client open up and gain further assessment of pain in this client. Awareness of the amount of wine consumption in a week will be helpful to-guide which kind of detoxification will be needed. Notifying the primary care provider about the situation and arranging for a joint conference are important for the client's safety and recovery. How the client is getting the wine is least important because there are so many possibilities such a weekly shopping trips in the facility van or having friends or family bring it in.

 CN: Safety and infection control; CL: Apply

53. 2. Hand washing with the correct technique is the best method for preventing cross-contamination. The hands serve as a source of infection. Waterless commercial products containing at least 60% alcohol are as effective at killing organisms as handwashing.

 CN: Management of care; CL: Synthesize

54. 3. The third maneuver is used to identify the presenting part. This maneuver is used to identify the part of the fetus that lies over the inlet to the pelvis. While facing the client, the nurse places the tips of the first three fingers

on the side of the woman's abdomen above the symphysis pubis and palpates deeply around the presenting part to identify its contour and size. The first maneuver involves using the tips of the fingers of both hands to palpate the uterine fundus. The second maneuver identifies the back of the fetus, and the fourth maneuver identifies the cephalic prominence.

CN: Reduction of risk potential; CL: Apply

55. 2. The stored glucose of muscle glycogen is the major fuel during sustained activity. Glucose production slows as the body begins to depend on fat stores for glucose and fatty acids. Protein is not the body's preferred energy source. Fat is a secondary source of energy. Water is not an energy source, although sufficient water is required to engage in aerobic activity without causing dehydration.

CN: Health promotion and maintenance; CL: Apply

56. 3. Fluctuation of fluid with respirations in the water seal column indicates that the system is functioning properly. If an obstruction were present in the chest tube, fluid fluctuation would be absent. Subcutaneous emphysema occurs when air pockets can be palpated beneath the client's skin around the chest tube insertion site. A leak in the system is indicated when bubbling occurs in the water seal column.

CN: Reduction of risk potential; CL: Apply

57. 4. It is important to dry the feet carefully after a bath to prevent a fungal infection. Clients with diabetes should seek medical attention when they injure their toes or feet to prevent complications. Iodine is highly toxic to the tissues. Clients with diabetes should inspect their feet daily and should wear shoes that support their feet while in the house.

CN: Reduction of risk potential; CL: Evaluate

58. 2. Diverticular rupture causes peritonitis from the release of intestinal contents (chemicals and bacteria) into the peritoneal cavity. A rigid abdominal wall results from a diverticular cavity, and the nurse should report this to the health care provider. The inflammatory response of the peritoneal tissue produces severe abdominal rigidity and pain, diminished intestinal motility, and retention of intestinal contents (air, fluid, and stool). Hyperactive bowel sounds, explosive diarrhea, and excessive flatulence do not indicate peritonitis.

CN: Reduction of risk potential; CL: Analyze

59. 1, 2, 3, 5. Pancreatitis, a chronic or acute inflammation of the pancreas, is a potentially life-threatening condition. Excessive alcohol intake and gallstones

are the greatest risk factors. Abdominal trauma can potentiate inflammation. Hyperlipidemia is a risk factor for recurrent pancreatitis. Hypertension and hypothyroidism are not associated with pancreatitis.

 CN: Reduction of risk potential; CL: Analyze

60. 3. The client most in need of validating safety is the mother who has received carboprost 1 hour ago for increased bleeding. Her bleeding level needs to be documented as having been evaluated at the beginning of the shift and to determine if it has decreased to within normal limits (ie, saturating <1 pad/h). The three stable clients will need to have an initial assessment by the oncoming nurse but can wait until the nurse can first assess the mother who is receiving carboprost. The mother with the 4-hour-old infant is able to breast-feed to maintain the blood glucose level, and the mother with the 3-day-old infant in the "biliblanket" is stable at this point.

 CN: Management of care; CL: Synthesize

61. 1. The nurse should firmly yet gently strike the chest wall with the hand cupped to make a hollow popping sound. A slapping sound indicates that an incorrect technique is being used. The area over the rib cage is percussed to loosen mucus from the underlying lung passages. The child should wear a thin piece of clothing (T-shirt) over the chest area to protect the skin without diminishing the effect of the percussion.

 CN: Reduction of risk potential; CL: Analyze

62. 1. The nurse should call to the nursing station to ask the nursing team for assistance. It is not necessary to page the physician because this is not an emergency, but the nurse will need to notify the physician of the client's death, and then also notify the family. A "code" should not be called because the client and family have designated a "do not resuscitate" status. Nursing personnel should begin postmortem care so that the family does not walk in unannounced to find their loved one deceased and looking disarrayed.

 CN: Management of care; CL: Synthesize

63. 2 lb or 0.9 kg. One pound or 0.45 kilograms of weight is approximately equivalent to 3,500 cal. Removing 1,000 cal/day results in a 2-lb (0.9-kg) weight loss per week (7,000 cal divided by 7 days). A client who wanted to lose 1 lb (0.45 kg) in a 7-day period would need to cut out 500 cal/day (3,500 cal divided by 7 days). It is unsafe to try to lose more than 2 lb (0.9 kg)/wk.

 CN: Health promotion and maintenance; CL: Apply

64. 1. The nurse should instruct the client to take the medication immediately

or as soon as she remembers that she missed the medication. There is only a slight risk that the client will become pregnant when only one pill has been missed, so there is no need to use another form of contraception. However, if the client wishes to increase the chances of not getting pregnant, a condom can be used by the male partner. The client should not omit the missed pill and then restart the medication in the morning because there is a possibility that ovulation can occur, after which intercourse could result in pregnancy. Taking two pills is not necessary and also will result in putting the client off her schedule.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

65. 1. Pain disorder is a somatoform disorder involving severe pain in one or more anatomic sites causing severe distress or impaired function. The statement, “I need to have a good cry about all the pain I've been in and then not dwell on it,” indicates improvement because the client has a realistic view of the physical symptoms and pain and is willing to let them go and move on. The other statements indicate the continued presence of denial, lack of insight, and the need for symptoms to manage anxiety.

 CN: Psychosocial integrity; CL: Evaluate

66. 4. The nurse needs to collect additional information about the client's report about hearing voices. Assessing the content of hallucinations is essential to determine whether they are command hallucinations that the client might act on. Asking about what the neighbor has been doing or telling the client that the neighbor won't visit indirectly reinforces the delusion about the neighbor. Although determining the onset and duration of the voices is important, the nurse needs to assess the content of the hallucinations first.

 CN: Psychosocial integrity; CL: Synthesize

67. 3. A client with severe diarrhea loses large amounts of bicarbonate, resulting in metabolic acidosis. Metabolic alkalosis does not result in this situation. Diarrhea does not affect the respiratory system.

 CN: Reduction of risk potential; CL: Analyze

68. 4. Serum osmolality indicates the water balance of the body. A normal plasma osmolality between 275 and 295 mOsm/kg (mmol/kg) indicates that the fluid volume excess has been resolved. A weight reduction of 10% may not necessarily return the client to a state of normal serum osmolality. Clients with excess fluid volume do not necessarily have pain or abnormal arterial blood gas values.

 CN: Reduction of risk potential; CL: Synthesize

69. 3. Exactly why rheumatic fever follows a streptococcal infection is not known, but it is theorized that an antigen-antibody response occurs to an M protein present in certain strains of streptococci. The antibodies developed by the body attack certain tissues such as in the heart and joints. Antistreptolysin O titer findings show elevated or rising antibody levels. This blood finding is the most reliable evidence of a streptococcal infection.

CN: Reduction of risk potential; CL: Analyze

70. 1. The ability to communicate with a person of the same language would be an advantage, an opportunity for socialization and support for the new mother who speaks Spanish. If a Spanish-speaking mother were placed with the client who also had a baby in SCN, she would have no communication opportunity, and the same would apply for rooming with the mother who has had a cesarean section. The client who is non–English speaking does not identify the language spoken, and the nurse cannot assume that it is Spanish.

CN: Management of care; CL: Synthesize

71. 3. The nurse should call the surgeon's office so that arrangements can be made for the client to donate a unit of his blood for possible future autotransfusion. This must be done in sufficient time before surgery so that the client is not at risk for being anemic at the time of the scheduled procedure. The client's request must be scheduled through the surgeon's office because the surgeon has ultimate responsibility for the client. The nurse can document that the surgeon's office was notified of the client's request. Notifying the hematology laboratory or blood bank is not an appropriate response.

CN: Pharmacological and parenteral therapies; CL: Synthesize

72. 1. Nurses should verify that clients having surgery discontinued use of any blood thinners to prevent postoperative bleeding. Prior to bowel resection the client should follow a high-residue diet with increased fluids. Abdominal tightening exercises are not necessary before this surgery. Clients may write a will before surgery, but the nurse does not have to inquire about it.

CN: Reduction of risk potential; CL: Synthesize

73. 1, 3. When a client collects stool for occult blood, the nurse should instruct the client to avoid eating meat, especially red meat, for 1 to 3 days before the sample collection because meat eliminated in the stool can lead to false-positive results. Eating foods high in fiber a few days before sample collection may be recommended because doing so improves the chances of finding occult blood if a lesion is present. The client should take stool samples

from different sites of the stool for a better sample. The stool sample should be covered to protect everyone from body secretions. The specimen does not have to be sent to the laboratory immediately. Some medications, herbs, foods, and activities can lead to false results of the occult testing. For example, iron pills, turnips, and horseradish lead to false-positive results. Vitamin C leads to false-negative results. Some anti-inflammatory drugs and aspirin should be avoided due to antiplatelet properties that increase the risk of gastrointestinal bleeding.

 CN: Reduction of risk potential; CL: Evaluate

74. 3. The most appropriate intervention is to offer the client frequent mouth care to moisten the dry oral mucosa. Reexplaining why the client cannot drink may be helpful but will not relieve the thirst. Ice chips cannot be given to a client who is on NPO status. Diverting the client's attention does not help manage the thirst.

 CN: Basic care and comfort; CL: Synthesize

75. 2. This client is demonstrating classic symptoms of hypothyroidism. Primary hypothyroidism results from pathologic changes in the thyroid gland. In this case, the thyroid gland cannot secrete sufficient amounts of thyroid hormone, leading to a decrease in cellular metabolic activity, decreased oxygen consumption, and decreased heat production. Cushing's disease is manifested by a buffalo hump, moonface, hypertension, fatigability, and weakness, resulting from the inappropriate release of cortisol. Hyperthyroidism, or Graves' disease, is manifested by increased appetite with weight loss, increased anxiety, hand tremors, palpitations, heat intolerance, and insomnia. A pituitary tumor can have many symptoms, depending on the location.

 CN: Reduction of risk potential; CL: Analyze

76. 3. After the symptoms of puberty, such as increased hair growth and enlargement of the breasts, are noticed, menstruation typically begins within 30 months.

 CN: Health promotion and maintenance; CL: Apply

77. 2. Epstein's pearls are tiny, hard, white nodules found in the mouth of some neonates. They are considered normal and usually disappear without treatment. Koplik's spots, associated with measles in children, are patchy and bright red with a bluish-white speck in the middle. Precocious teeth are actual teeth that some neonates have at birth. Usually, only one or two teeth are present. *Candida albicans,* or thrush, is not apparent in the mouth immediately after birth but may appear a day or 2 later. This infection is manifested by yellowish-white

spots or lesions that resemble milk curds and bleed when attempts are made to wipe them away.

CN: Health promotion and maintenance; CL: Analyze

78. 1, 2. The initial signs of esophageal atresia and TEF include lots of frothy mucus and unexplained episodes of cyanosis usually caused by overflow of mucus from the esophagus. Loose stools and poor gag reflex are not signs of TEF. Initial weight loss is common in newborns and not related to TEF.

CN: Reduction of risk potential; CL: Analyze

79. 1. Adequate circulatory status is the most important factor in the healing process of an infected decubitus ulcer. Blood flow to the area must be present to bring nutrients and prescribed antibiotics to the tissues. Rest and a balanced diet are essential to health maintenance but are not the priority for healing an infected decubitus ulcer. A fluid intake of 2,000 to 3,000 mL/day, if not contraindicated, is recommended to provide hydration to the client's tissues.

CN: Reduction of risk potential; CL: Synthesize

80. 2. The nurse's initial response should be to withhold the digoxin. The nurse should then notify the physician if the apical pulse is 60 bpm or lower because of the risk of digoxin toxicity. The charge nurse does not need to be notified, but the nurse needs to document the notification and follow-up in the chart.

CN: Pharmacological and parenteral therapies; CL: Synthesize

81. 2. In an emergency in which the neonate's head is already being born, the first action by the nurse should be to check for the presence of a cord around the neonate's neck. If the cord is present, the nurse should gently remove it from around the neck. The mother should be told to breathe gently and avoid forceful bearing-down efforts, which could lead to lacerations. Although blood and bodily fluid precautions are always present in client care, this is an emergency. If possible, the nurse should put on gloves. Suctioning the mouth can be done after the nurse has checked that the cord is not around the neonate's neck. Telling the mother that help is on the way is not reassuring because emergency medical technicians may take some time to arrive. Birth is imminent because the neonate's head is emerging.

CN: Reduction of risk potential; CL: Synthesize

82. 2. The ulna heals in approximately 12 weeks. The femur takes approximately 24 weeks to heal because of the size of the bone and the muscle forces exerted on the femur. Skeletal traction does not delay healing but can

actually promote healing by properly aligning the fracture.

CN: Reduction of risk potential; CL: Synthesize

83. 2. The client needs to know that there is a cause for the delirium, that there is hope for treatment, and that medications can help decrease anxiety. Giving medications can help the anxiety, but the client also needs an explanation about the condition. Saying that the more the client worries, the worse the delirium will get is inappropriate and most likely would add to the client's anxiety.

CN: Psychosocial integrity; CL: Synthesize

84. 1. The client understands the instructions when she says she should avoid contact sports because they may result in injury to the client and the fetus. Learning to ski while pregnant is not recommended because injury may occur. Scuba diving should be avoided because depth pressures could cause fetal damage. Hot tubs should be avoided during the first trimester because sitting in them can result in fetal hyperthermia and fetal hypoxia. Mild exercises, such as walking, can help strengthen the muscles and prevent some discomforts such as backache.

CN: Health promotion and maintenance; CL: Evaluate

85. 4. Third-degree heart block occurs when atrial stimuli are blocked at the atrioventricular junction. Impulses from the atria and ventricles are conducted independently of each other. The atrial rate is 60 to 100 bpm; the ventricular rate is usually 10 to 60 bpm.

CN: Reduction of risk potential; CL: Analyze

86. 1. The nurse should call the oncology unit to institute a transfer. The nurse handling chemotherapy agents should be specially trained. It is an unwise use of nursing resources to send a nurse from one unit to administer medications to a client on another unit. It is better to centralize and send the client who needs chemotherapy to one unit. Even if the pharmacy mixes the agent, the drug must be administered by a specially trained nurse.

CN: Management of care; CL: Synthesize

87. 2. After surgery, the most important nursing goal is to prevent infection. Surgery involves an incision, which places the infant at risk for infection. The infant with this type of procedure does have discomfort, which can be relieved with acetaminophen (Tylenol), and managing pain is important but not the priority. The infant may be in arm restraints or have the cuff of the sleeve pinned to the diaper or pants. It is important that the infant not touch the incision line or

disrupt the sutures, but the infant is not at risk for problems related to immobility. There is no indication that the parents need to improve their skills, but the nurse can support the family as they would be reacting normally with a first reaction of shock.

CN: Reduction of risk potential; CL: Analyze

88. 1. An appropriate outcome for the client with rheumatoid arthritis is that he will adopt self-care behaviors to manage joint pain, stiffness, and fatigue and be able to perform activities of daily living. Range-of-motion (ROM) exercises can help maintain mobility, but it may not be realistic to expect the client to maintain full ROM. Depending on the disease progression, there may be further development of pain and joint deformity, even with appropriate therapy. It is important for the client to understand the importance of taking the prescribed drug therapy even if symptoms have abated.

CN: Reduction of risk potential; CL: Synthesize

89. 4. Hydrotherapy wound cleaning is very painful for the client. The client should be medicated for pain about 30 minutes before the treatment in anticipation of the increased pain the client will experience. Wounds are debrided but excessive fluids are not lost during the hydrotherapy session. However, electrolyte loss can occur from open wounds during immersion, so the sessions should be limited to 20 to 30 minutes. There is no need to limit food or fluids 45 minutes before hydrotherapy unless it is an individualized need for a given client. Topical antibiotics are applied after hydrotherapy.

CN: Reduction of risk potential; CL: Create

90. 1. Hepatitis B immune globulin is given as prophylactic therapy to individuals who have been exposed to hepatitis B. Interferon has been approved to treat hepatitis B. Hepatitis B surface antigen is a diagnostic test used to detect current infection. Amphotericin B is an antifungal.

CN: Pharmacological and parenteral therapies; CL: Apply

91. 1. When examining the tympanic membrane of a child younger than age 3 years, the nurse should pull the pinna down and back. For an older child, the nurse should pull the pinna up and back to view the tympanic membrane.

CN: Reduction of risk potential; CL: Apply

92. 3. In the compensatory stage of shock, the client exhibits moderate tachycardia. If the shock continues to the progressive stage, decreased urinary output, hypotension, and mental confusion develop as a result of failure to perfuse and ineffective compensatory mechanisms. These findings are

indications that the body's compensatory mechanisms are failing.

CN: Reduction of risk potential; CL: Analyze

93. 2. Hydrochlorothiazide is a thiazide diuretic. Muscle weakness can be an indication of hypokalemia. Polyuria is associated with this diuretic, not urinary retention. Confusion and diaphoresis are not side effects of hydrochlorothiazide.

CN: Pharmacological and parenteral therapies; CL: Analyze

94. 1. The ability to remember an old song is related to long-term memory, which persists after short-term memory is lost. Therefore, the nurse should respond by providing the son with this information. Stating that the nurse is happy to hear about the change and that the client is getting better is inappropriate and inaccurate. This statement ignores the issue of long-term versus short-term memory. Telling the client not to get his hopes up because the improvement is only temporary is inappropriate. The information provided does not indicate that the client has expressive aphasia, which would be suggested by the statement that the client can't talk to the son.

CN: Psychosocial integrity; CL: Analyze

95. 1. A specimen for culture and sensitivity should be sent to the laboratory promptly so that a smear can be taken before organisms start to grow in the specimen.

CN: Reduction of risk potential; CL: Apply

96. 1. The client is in a crisis and has a high anxiety level. Holding the client's hands and encouraging the client to slow down and take a deep breath convey caring and helps decrease anxiety. Telling the client to calm down or stop worrying offers no concrete directions for accomplishing this task. It is unknown from the data who was at fault in the accident. Therefore, it is inappropriate for the nurse to state that it wasn't the client's fault.

CN: Psychosocial integrity; CL: Synthesize

97. 3. Many women who acquire gonorrhea are asymptomatic or experience mild symptoms that are easily ignored. They are not necessarily more reluctant than men to seek medical treatment, but they are more likely not to realize they have been affected. Gonorrhea is easily transmitted to all women and can result in serious consequences, such as pelvic inflammatory disease and infertility.

CN: Management of care; CL: Create

98. 4. Tingling and numbness of the toes would be the earliest indication of circulatory impairment. Inability to move the toes and cyanosis are later

indicators. Cast tightness should be investigated because cast tightness can lead to circulatory impairment; it is not, however, an indicator of impairment.

 CN: Reduction of risk potential; CL: Analyze

99. 3. The client should be encouraged to report painful urination or urinary retention. Lesions may appear 2 to 12 days after exposure. The client is capable of transmitting the infection even when asymptomatic, so a barrier contraceptive should be used. Drinking extra fluids will not stop the lesions from forming.

 CN: Management of care; CL: Synthesize

100. 1. The nurse should initiate fetal and contraction monitoring for this client upon arrival to the unit. This gives the nurse data regarding changes in fetal and maternal contraction status before completing the other prescriptions. Next, the betamethasone would be given to begin the maturation process for the fetal lungs. Next, the nurse should start an intravenous infusion to provide a line for immediate intravenous access, if needed, and provide hydration for the client. The nurse should obtain the urine specimen prior to administering any antibiotic therapy, if prescribed.

 CN: Management of care; CL: Synthesize

101. 2. Severe hypoperfusion to all vital organs results in failure of the vital functions and then circulatory collapse. Hypotension, anuria, respiratory distress, and acidosis are other symptoms associated with irreversible shock. The client in irreversible shock will not be alert.

 CN: Reduction of risk potential; CL: Analyze

102. 1. Pulmonary embolism is a potentially life-threatening complication of deep vein thrombosis. The client's change in mental status, tachypnea, and tachycardia indicates a possible pulmonary embolism. The nurse should promptly notify the doctor of the client's condition. Administering a sedative without further evaluation of the client's condition is not appropriate. There is no need to elicit a positive Homans' sign; the client is already diagnosed with deep vein thrombosis. Increasing the IV flow rate may be an appropriate action but not without first notifying the physician.

 CN: Reduction of risk potential; CL: Synthesize

103. 2. Coping with the chronic tinnitus of Ménière's disease can be very frustrating. Providing background sound, such as music, can help camouflage the low-pitched, roaring sound of tinnitus. Maintaining a quiet environment can make the sounds of tinnitus more pronounced. Avoiding caffeine and nicotine is recommended because this can decrease the occurrence of the tinnitus. However,

avoiding these substances does not help the client with coping with tinnitus when it occurs. Taking a sedative does not affect tinnitus.

 CN: Reduction of risk potential; CL: Synthesize

104. 2. The child's signs and symptoms in conjunction with the acute onset suggest possible croup or epiglottiditis. The priority diagnosis at this time is airway obstruction. The airway may become completely occluded by the epiglottis at any time. Although the child is probably experiencing fear and anxiety, and the client has respiratory distress, the immediate priority is to establish and maintain a patent airway. No evidence is provided to support the potential for aspiration.

 CN: Reduction of risk potential; CL: analyze

105. 3. The nurse should first determine why the client wants to sit up and then, if needed delegate someone to assist the client. Loosening the restraints will not keep the client safe in bed. Raising the side rails and elevating the head of the bed do not address the client's needs.

 CN: Management of care; CL: Synthesize

106. 4. Diabetic retinopathy involves background and proliferative retinopathy. Both forms are associated with vascular changes in the basement membrane of the arterioles and capillaries of the choroid and retina. Neuropathy is usually associated with the lower extremities.

 CN: Reduction of risk potential; CL: Analyze

107. 2. The 70-year-old woman with syncopal episodes is at greatest risk for falling. The nurse should assess the client's gait and balance and the syncopal episodes. The 22-year-old man with upper body fractures and the 50-year-old man with angina are not at risk for falling. The 30-year-old woman could be at risk for falling, but she is at less risk than the 70-year-old client with syncope.

 CN: Management of care; CL: Analyze

108. 3. The baseline laboratory data that are established before a client is started on tissue plasminogen activator or alteplase recombinant include hematocrit, hemoglobin level, and platelet count.

 CN: Reduction of risk potential; CL: Apply

109. 3. The most appropriate long-term goal for the client with hypertension is to commit to lifelong therapy. A significant problem in the long-term management of hypertension is compliance with the treatment plan. It is essential that the client understand the reasons for modifying lifestyle, taking

prescribed medications, and obtaining regular health care. Limiting stress, losing weight, and monitoring blood pressure are important aspects of care for the client with hypertension; however, the treatment plan must be individualized to include aspects of care that are appropriate for each client.

 CN: Health promotion and maintenance; CL: Synthesize

110. 1. The nurse should work with the client to individualize the plan of care for managing pain. Cancer pain is best managed with a combination of medications, and each client needs to be worked with individually to find the treatment regimen that works best. Cancer pain is commonly undertreated because of fear of addiction. The client who is in pain needs the appropriate level of analgesic and needs to be reassured that addiction is unlikey. Cancer pain is best treated with regularly scheduled doses of medication. Administering the medication only when the client asks for it will not lead to adequate pain control. As drug tolerance develops, the dosage of the medication can be increased.

 CN: Basic care and comfort; CL: Synthesize

111. 4. The client needs further instructions when she says, “I can continue to work at my job at the automobile factory until labor starts.” The goal is to avoid preterm labor. Because the client is experiencing severe hydramnios, she will most likely be maintained on bed rest to increase uteroplacental circulation and reduce pressure on the cervix. Hydramnios has been associated with increased weight gain caused by increased amniotic fluid volume. Hydramnios has been associated with gastrointestinal disorders in the fetus, such as tracheoesophageal fistula with stenosis or intestinal obstruction. The client should continue to eat high-fiber foods and should avoid straining, which could lead to ruptured membranes. Stool softeners may also be prescribed. The client should report any symptoms of fluid rupture or labor.

 CN: Reduction of risk potential; CL: Evaluate

112. 1. The stationary bicycle is the most appropriate training modality because it is a non–weight-bearing exercise. Interval training involves rest and exercise. The time that the individual exercises on the stationary bicycle is increased with improved functional capacity, and the rest time is decreased.

 CN: Health promotion and maintenance; CL: Synthesize

113. 1. The nurse should first plan to relieve the nausea and vomiting; if these continue, the client is at risk for dehydration and electrolyte imbalance. The client's poor appetite is likely related to the underlying health problem and is

not the priority; the nausea does not improve the appetite, and relieving the nausea may allow the client an opportunity to eat and drink. The client has jaundice but does not report uncomfortable symptoms such as pruritus. The abdominal spasms may be related to nausea and vomiting and can be assessed again when the nausea and vomiting have stopped.

 CN: Reduction of risk potential; CL: Analyze

114. 1. All clients who are at risk for pressure ulcer development should be identified on admission to health care facilities so that preventive actions can be implemented by the nursing staff. These preventive actions need to be individualized to the client, so automatic placement of all at-risk clients on an every-2-hour turning schedule, a specialty bed, or a high-protein, high-carbohydrate diet is not appropriate.

 CN: Reduction of risk potential; CL: Apply

115. 3. Visual disturbances are a symptom of digoxin (Lanoxin) toxicity. These disturbances can include double, blurred, or yellow vision. Cardiovascular manifestations of digoxin toxicity include bradycardia, other dysrhythmias, and pulse deficit. Gastrointestinal symptoms include anorexia, nausea, and vomiting.

 CN: Pharmacological and parenteral therapies; CL: Analyze

116. 2. Irradiated skin can become dry and irritated, resulting in itching and discomfort. The client should be instructed to clean the skin gently and apply nonperfumed, nonirritating lotions to help relieve dryness. Taking an antihistamine does not relieve the skin dryness that is causing the itching. Heat should not be applied to the area because it can cause further irritation. Medicated ointments, especially corticosteroids, which are controversial, should not be applied to the skin without the prescription of the radiation therapist.

 CN: Reduction of risk potential; CL: Evaluate

117. 1. The mask is appropriate because it covers the nose and mouth and fits snugly against the cheeks and chin. Masks that are too large may cover the eyes. Masks that are too small obstruct the nose. The mask does not need to be covered with a cloth.

 CN: Management of care; CL: Evaluate

118. 4. In preparation for a thoracentesis, the client should be asked to sit forward and place his arms on the bedside table for support. This position provides access to the chest wall and intercostal spaces for insertion of the needle. The supine, Sims', or prone position would not provide adequate access to the chest wall or separate the intercostal spaces sufficiently for needle

insertion.

CN: Reduction of risk potential; CL: Apply

119. 4. The antidote for heparin is 1% protamine sulfate. Vitamin K is the antidote for warfarin, an oral anticoagulant. Thrombin is a topical anticoagulant.

CN: Pharmacological and parenteral therapies; CL: apply

120. 1. At this time, the client's anger is not out of control, so empathy and talking are appropriate to diffuse the anger. Using time-out is appropriate when the client's anger is escalating and the client can no longer talk about the anger rationally. Restraints are appropriate only when there is imminent risk of harm to the client or others. Future strategies are discussed after the initial incident is resolved.

CN: Psychosocial integrity; CL: Synthesize

121. 1. The nurse's first action after the removal of a NG tube is to provide the client with oral hygiene. Then it is appropriate to give the client liquids to drink if the client is no longer on nothing-by-mouth status. There is no association between removal of an NG tube and having the client cough and deep breathe. Auscultating the client's bowel sounds should be done before removal of the NG tube.

CN: Basic care and comfort; CL: Synthesize

122. 3. Heat applications cause vasodilation, which promotes circulation to the area, and increase tissue metabolism and leukocyte mobility. Heat applications do not prevent swelling; applications of cold are used to prevent swelling by causing vasoconstriction. Moist heat applications do not reduce bruising or scaling on the skin.

CN: Reduction of risk potential; CL: Evaluate

123. 1. Thick, cloudy amniotic fluid indicates an intrauterine infection. Typically, the client has a fever, lethargy, and malaise. Greenish-colored amniotic fluid is associated with meconium staining. A strong yellowish color is associated with erythroblastosis fetalis because of the presence of bilirubin and hemolyzed red blood cells. The normal color of amniotic fluid is clear or with a very slight yellow tint later in pregnancy.

CN: Reduction of risk potential; CL: Analyze

124. 3. When finishing a 24-hour urine collection, the final voided urine is saved and added to the collection container. The first urine specimen, voided at 7 AM Monday, is discarded. The urine is not sent for a urine culture. It is not

necessary to separate each day's collection of urine.

CN: Reduction of risk potential; CL: Apply

125. 2. Hypoalbuminemia occurs in cirrhosis because the liver cannot synthesize albumin. This causes a decrease in colloidal osmotic pressure, resulting in ascites. Hyperkalemia is not an expected electrolyte imbalance of cirrhosis. The aspartate aminotransferase and alanine aminotransferase values are increased in liver disease.

CN: Reduction of risk potential; CL: Analyze

126. 2. At this time, the infant can be given the vaccines. The fact that the child's sibling is immunosuppressed because of chemotherapy is not a reason to withhold the vaccines. The fact that the child has a cold is not grounds for delaying the immunizations. However, if the child had a high fever, the immunizations would be delayed.

CN: Health promotion and maintenance; CL: Synthesize

127. 3. The primary cause of disability and death in children is injury from accidents. Teaching safety measures to children and their parents is the best way to decrease injury and accidents.

CN: Management of care; CL: Synthesize

128. 1. A major goal of postoperative care for the client who has had an incisional cholecystectomy is the prevention of respiratory complications. Because of the location of the incision, the client has a difficult time breathing deeply. Use of incentive spirometry promotes chest expansion and decreases atelectasis. Performing leg exercises each shift is not frequent enough; they should be performed hourly. Maintaining a weight reduction diet may be appropriate for the client, but it is not the highest priority in the immediate postoperative phase. Promoting wound healing is important, but respiratory complications are most common after a cholecystectomy.

CN: Reduction of risk potential; CL: Synthesize

129. 1. In response to hearing a noise, normally hearing infants blink or startle and stop body movements. Shy and withdrawn behaviors are characteristic of older children with hearing impairment. Squealing occurs in 90% of infants by age 4 months. Most infants can say “da-da” by age 9 months.

CN: Health promotion and maintenance; CL: Evaluate

130. 3. Continuous irrigation, usually consisting of sterile normal saline, is used after TURP to keep blood clots from obstructing the catheter and impeding

urine flow. Antibiotics may be instilled in the bladder with the use of an irrigating solution, but this is not the primary reason for using continuous irrigation in TURP. The irrigating solution may secondarily help prevent bladder distention because it keeps the catheter from becoming obstructed.

CN: Reduction of risk potential; CL: Apply

131. 3. A distended bladder produces dullness when percussed because of the presence of urine. Hyperresonance is a percussion sound that is present in hyperinflated lungs. Tympany, a loud drumlike sound, occurs over gas-filled areas such as the intestines. Flat sounds occur over very dense tissue that has no air present.

CN: Reduction of risk potential; CL: Analyze

132. 2. Major accidents can induce feelings similar to those of victims of other kinds of disasters and crime. Therefore, the nurse calls the crisis nurse to assist the passengers with their feelings of victimization. Passengers may mourn the loss of a vacation, but with no fatalities, major grief reactions are not expected. Other personnel can take calls from relatives, while the crisis nurse helps the passengers. Psychiatric hospitalization is a premature assumption.

CN: Psychosocial integrity; CL: Analyze

133. 1. When placed on the abdomen, a neonate pulls the legs up under the body, which puts tension on the perineum. Therefore, after surgery, the neonate should be positioned either supine with the legs suspended at a 90-degree angle or on either side with the hips elevated.

CN: Reduction of risk potential; CL: Apply

134. 1. The child with meningococcal meningitis requires droplet precautions for at least the first 24 hours after effective therapy is initiated to reduce the risk of transmission to others on the unit. After the child has been placed on droplet precautions, other actions, such as taking the child's vital signs, asking about medication allergies, and inquiring about the health of siblings at home, can be performed.

CN: Management of care; CL: Synthesize

135. 1. Teenagers usually enjoy activities with peers in preference to socializing with their parents or siblings. Peer relationships help the adolescent develop self-identity.

CN: Health promotion and maintenance; CL: Synthesize

136. 2, 3. Teens are very concerned about their body image and knowing

about the size of the scar is important to them. Typically, teens return to school in 1 week. While hospitalized, friends can visit during visiting hours. Clients are usually hospitalized for an uncomplicated appendectomy for about 24 hours. Antibiotics are not routinely given to prevent an infection. The dressing is removed within a few days.

 CN: Reduction of risk potential; CL: Synthesize

137. 2. Morphine can cause urinary retention. The nurse should assess the client for urinary hesitancy or retention and note the urinary output. It is not necessary to take the apical heart rate after each dose of morphine. Mental status should be assessed after each dose because morphine can cause such effects as sedation, delirium, and disorientation. Assessing for pedal edema is not necessary.

 CN: Pharmacological and parenteral therapies; CL: Analyze

138. 4. Infection is the greatest concern to the nurse. Infection occurs more frequently because of the number of procedures performed on clients that require this therapy and people they come in contact with in the hospital. Infection can be reduced if proper infection control techniques are used and human contact is reduced. Deficiencies and toxicities of nutrients are rare because of the use of standard protocols and prescriptions for TPN formulas. Hyperglycemia can occur with TPN administration; however, all clients receiving TPN have their serum glucose concentration monitored frequently, and the hyperglycemia can easily be managed by adding insulin to the TPN solution. An infection is a much more serious complication.

 CN: Pharmacological and parenteral therapies; CL: Analyze

139. 2. The nurse should assess for signs of impending shock such as diaphoresis. The client would have hypotension, dysuria, and cool skin.

 CN: Pharmacological and parenteral therapies; CL: Analyze

140.

3. Level of consciousness.

4. Motor strength.

1. Vital signs.

2. Decreased urine output.

In order of priority, the nurse would assess level of consciousness, motor strength, vital signs, and then decreased urine output. Level of consciousness is the best indication of brain function. If the child's condition deteriorates, the nurse would observe changes in level of consciousness before any other changes. Motor strength is primarily assessed as a voluntary action. With a change in level of consciousness, there may be changes in motor function. If the client's fluids are restricted, then the urine output would decrease. In children, the usual urine output is 1 mL/kg/h.

 CN: Reduction of risk potential; CL: Synthesize

141. 2. The urinary appliance should be emptied before the pouch is one-third full to prevent urinary reflux. The appliance should be attached to a leg bag at night to allow for adequate drainage. It is not appropriate to administer prophylactic antibiotics when incorporating positive self-care activities into the client's routine can prevent most urinary tract infections. The urinary appliance is not changed daily. If no leakage occurs and the client's skin remains free from irritation, the appliance can be left in place for 1 week or more.

 CN: Basic care and comfort; CL: Synthesize

142. 1. Preoxygenating the client before suctioning helps prevent the development of hypoxia during the procedure. The suction catheter is inserted about 5 to 6 inches (12.7 to 15.2 cm) into the cannula. A bolus of 3 to 5 mL of sterile normal saline solution may be inserted into the cannula before suctioning to stimulate coughing and loosen secretions. The nurse uses sterile technique when suctioning a client.

 CN: Reduction of risk potential; CL: Apply

143. 3. Because the toddler has a severe diaper rash, it may be best to change all that the parents are doing. The buttocks need to be washed thoroughly with mild soap and dried well. In fact, it is helpful to leave the diaper off and expose the buttocks to the air. Baby wipes commonly contain additives and perfumes that may be irritating to the baby's sensitive skin. The diaper needs to be changed more often than every 4 to 6 hours. Otherwise, the moist diaper environment will continue to irritate the skin, causing the rash to worsen. Powder has limited absorbing ability and will most likely irritate the area more. In addition, some powders contain perfumes or are scented and can irritate the skin.

 CN: Basic care and comfort; CL: Synthesize

144. 2. The toddler is screaming for a reason, so it is most therapeutic to ask the mother why the child is screaming. This type of question is nonaccusatory, just seeking information. Asking the mother what happened between her and the child makes the assumption that something did happen and limits the amount of information to be gained from the question. Asking whether something caused the child to be upset makes an assumption that something happened and limits the answer to a yes or no response, cutting off communication. Asking whether the mother has tried to calm the child is accusatory and also limits the response to yes or no, thus cutting off communication.

 CN: Health promotion and maintenance; CL: Synthesize

145. 4. The client will need to avoid extremes of motion in the hip to avoid dislocation. The hip should not be flexed more than 90 degrees, internally rotated, or legs crossed. It is not possible to safely sit in the bathtub without flexing the hip beyond the recommended 90 degrees. The client can implement the prescribed exercise program at the time of discharge home. The client should take care not to stress the hip for 3 to 6 months after surgery. An elevated toilet seat will be necessary during the recovery from surgery.

 CN: Reduction of risk potential; CL: Evaluate

146. 1, 2, 5. The common presenting symptoms of infectious mononucleosis vary greatly but commonly include fever, malaise, sore throat, and lymphadenopathy. Skin rash, cold symptoms, abdominal pain, and weight loss are rarely presenting symptoms.

 CN: Reduction of risk potential; CL: Analyze

147. 1. The nurse should place the nondominant hand above the symphysis pubis and the dominant hand at the umbilicus to palpate the fundus. This prevents uterine inversion and trauma, which can be very painful to the client. The nurse should ask the client to assume a supine, not side-lying, position with the knees flexed. The fundus can be palpated in this position, and the perineal pads can be evaluated for lochia amounts. The fundus should be massaged gently if the fundus feels boggy. Vigorous massaging may fatigue the uterus and cause it to become firm and then boggy again. The nurse should ask the client to void before fundal evaluation. A full bladder can cause discomfort to the client, the uterus to be deviated to one side, and postpartum hemorrhage.

 CN: Health promotion and maintenance; CL: Apply

148. 2. A reactive nonstress test is a positive sign indicating that the fetus is doing well at this point in the pregnancy. For a nonstress test to be a reactive test,

at least two accelerations (15 beats or more) of the fetal heart rate lasting at least 15 seconds must occur after movement. If the fetus were compromised, the nonstress test would demonstrate no accelerations in fetal heart rate; a contraction stress test would show fetal heart rate decelerations during simulated labor. Late decelerations are associated with a positive or abnormal contraction stress test. No accelerations in a 20-minute period during a nonstress test may mean that the fetus is sleeping; however, this is interpreted as a nonreactive nonstress test.

CN: Reduction of risk potential; CL: Apply

149. 3. Right-sided heart failure causes venous congestion resulting in such symptoms as peripheral (dependent) edema, splenomegaly, hepatomegaly, and neck vein distention. Intermittent claudication is associated with arterial occlusion. Dyspnea and crackles are associated with pulmonary edema, which occurs in left-sided heart failure.

CN: Reduction of risk potential; CL: Analyze

150. 1. To help prevent flexion deformities, a client with rheumatoid arthritis should lie in a prone position in bed for about ½ hour several times a day. This positioning helps keep the hips and knees in an extended position and prevents joint flexion. Low Fowler's, modified Trendelenburg, and side-lying positions do not prevent hip flexion.

CN: Basic care and comfort; CL: Synthesize

151. 2. Administration of an epidural anesthetic can result in a hypotensive effect on maternal blood pressure. Therefore, the priority assessment is the mother's blood pressure. Ephedrine or wedging the client to a position to keep pressure off the vena cava, such as on the left side, can be used to elevate maternal blood pressure should it drop too low. Epidural anesthesia has no effect on the level of consciousness or the client's cognitive function. Although the client's contraction pattern may decrease in frequency after administration of the anesthesia, the priority assessment is the client's blood pressure. After blood pressure is maintained, contractions can be assessed.

CN: Pharmacological and parenteral therapies; CL: Analyze

152. 1. The client's assessment findings indicate that the client is in the latent phase of the first stage of labor. Therefore, the nurse should plan to assist the client with comfort measures and breathing techniques to relieve discomfort. The client can move around, walk, or ambulate at this phase of labor. If the client chooses to remain in bed, a left side-lying position provides the greatest

perfusion. It is too early for the client to have an epidural anesthetic. Epidural anesthesia is usually administered when the cervix is dilated 4 to 5 cm. The fetal heart rate is normal, so internal fetal monitoring is not warranted at this time.

CN: Health promotion and maintenance; CL: Synthesize

153. 4. Hypokalemia is one of the most common causes of digoxin (Lanoxin) toxicity. It is essential that the nurse carefully monitor the potassium levels of clients taking digoxin to avoid toxicity. Low serum potassium levels can cause cardiac dysrhythmias.

CN: Pharmacological and parenteral therapies; CL: Apply

154. 3. Current pain guidelines recommend the removal of meperidine from formularies and the substitution of morphine commonly administered by patient-controlled analgesia. Meperidine can be prescribed for severe pain, but its use is limited by the high incidence of neurotoxicity (seizures) associated with the accumulation of its metabolite, normeperidine. It is contraindicated in clients with acute pain lasting more than 2 days and in those for whom large daily doses (more than 600 mg) are needed. It would be inappropriate to urge the client to take the acetaminophen and codeine to prevent addiction. Addiction is a psychological condition in which a client is driven to take drugs for reasons that are not therapeutic. The client is in pain and her need for the morphine is therapeutic. Although the client may obtain some relief from relaxation exercises, this alone is not sufficient to provide pain relief.

CN: Pharmacological and parenteral therapies; CL: Synthesize

155. 1. Infants at age 7 months are not capable of drinking from a cup without spilling. At age 6 months, infants can partially lift their weight on the hands, enjoy imitating sounds, and are developing separation anxiety.

CN: Health promotion and maintenance; CL: Analyze

156. 3. According to Erikson, a child of 13 years is normally seeking to meet the need to develop personal identity. Personal values are a component of this identity. Developing a conscience is a component of achieving initiative during the preschool years. Developing a sense of competence is a component of achieving industry in the school-age years. Developing a lifetime vocation is a component of achieving generativity in adulthood.

CN: Psychosocial integrity; CL: Analyze

157. 4. Cardiomyopathy means that the myocardium is weak and irritable. Amiodarone is an antiarrhythmic and acts directly on the cardiac cell membrane. In this situation, amiodarone is used to increase the ventricular fibrillation

threshold. Amiodarone is contraindicated in sinus node dysfunction, heart block, and severe bradycardia.

CN: Reduction of risk potential; CL: Evaluate

158. 1. A frothy, purulent vaginal discharge in a sexually active female client is typically caused by a sexually transmitted disease such as trichomonas. Other diseases, such as chlamydia, may also be present. Both the client and the boyfriend need treatment after the disease is determined. Normal variations in female vaginal discharge should be clear to white, not frothy or purulent. The client should be instructed to wear cotton underwear and avoid pantyhose, wet gym clothes, and tight-fitting garments, such as jeans, so that air can circulate.

CN: Management of care; CL: Analyze

159. 4. The most common factor in skin breakdown is immobility. Right-sided paralysis, in which the client cannot perceive the need to change position and lacks control over movement of the extremities, is the condition most likely to lead to skin breakdown. It is essential that the nurse plan to change the client's position at least every 2 hours. Nutritional status and urinary incontinence can contribute to skin breakdown but neither is the most critical factor. Confusion does not directly influence skin breakdown.

CN: Reduction of risk potential; CL: Analyze

160. 1. Psychomotor retardation refers to a general slowdown of motor activity commonly seen in a client with depression. Movements appear lethargic, energy is absent or lacking, and performance of activity is slow and difficult. A flat affect reflects a lack of emotion. An unkempt appearance reflects lack of self-care. Avoiding eye contact reflects low self-esteem or suspiciousness.

CN: Psychosocial integrity; CL: Analyze

161. 3. A hydrocele, defined as fluid in the processus vaginalis, is determined when the scrotal sac can be transilluminated. A swelling in the scrotal area that can be reduced indicates an inguinal hernia. Both hydroceles and hernias can enlarge the scrotal sac, and both can be either unilateral or bilateral. A hernia typically is more obvious during crying.

CN: Reduction of risk potential; CL: Analyze

162. 1. When cleaning the skin around an incision and drain, the nurse should clean the incision and drain separately to avoid contaminating either wound. This is applying the principle of working from the least contaminated area to the most contaminated area. In this case, both areas are fresh wounds and should be kept separate.

CN: Management of care; CL: Apply

163. 4. Any injury to the mouth results in copious amounts of blood because the mouth is a highly vascular area. Because the nurse does not know the mother and does not speak Spanish, the most appropriate action is to give the mother the ice and demonstrate what she is to do. The child will be less fearful if the ice is applied by the mother. Calling for an interpreter is appropriate after caring for the immediate need of the child. Grabbing the child away will probably upset the mother more, further adding to the stress experienced by the child.

CN: Psychosocial integrity; CL: Synthesize

164. 4. Having the client deep breathe hourly is the most appropriate action for the assistant to take to help prevent pulmonary complications. The client should be turned at least every 2 hours. Keeping the client's head elevated will not prevent pulmonary complications. Suctioning the client is not an assistant's responsibility, nor does it prevent pulmonary complications.

CN: Management of care; CL: Evaluate

165. 1, 3. The desired outcome for the client with poor circulation to the extremities is evidence of adequate blood flow to the area. The temperature of the involved extremity is an important indicator for a client with peripheral vascular disease. The temperature will indicate the degree to which the blood supply is getting to the extremity. Warmth indicates adequate blood flow. Pain is also an indicator of blood flow. Pain, such as muscle pain, suggests ischemia and lack of oxygen that results when the oxygen demand becomes greater than the supply. Thus, a decrease in muscle pain with activity would suggest improvement in blood flow to the area. Improved respiratory status and clear lungs are unrelated to the poor tissue perfusion. Although participation in self-care measures is always helpful, this outcome not a result of establishing circulation to the extremities.

CN: Reduction of risk potential; CL: Evaluate

166. 3. When dextrose is abruptly discontinued, rebound hypoglycemia can occur. The nurse should assess the client for symptoms of hypoglycemia. Essential fatty acid deficiency is very unlikely to occur because some of these fatty acids are stored. Preventing dehydration or malnutrition is not the reason for tapering the infusion rate; the client's hydration and nutritional status and ability to maintain adequate intake must be established before TPN is discontinued.

CN: Pharmacological and parenteral therapies; CL: Apply

167. 1. During the third trimester, particularly in the seventh month of pregnancy, the client typically exhibits feelings of vulnerability and fear that the baby will be lost. Confirmation that the fetus is real occurs during the second trimester. Ambivalence is typically seen and resolved during the first trimester. Body image disturbance commonly occurs during the second trimester because of the profound changes that occur to the body during this time.

 CN: Health promotion and maintenance; CL: Analyze

168. 2. As the dye is injected, the client may experience a feeling of warmth, flushing of the face, and a salty taste in the mouth. The client should not experience chest pain or cold chills; these would be adverse reactions warranting close monitoring of the client.

 CN: Reduction of risk potential; CL: Evaluate

169. 4. Isoniazid competes for the available vitamin B_6 in the body and leaves the client at risk for developing neuropathies related to vitamin deficiency. Supplemental vitamin B_6 is routinely prescribed to address this issue. Avoiding sun exposure is a preventive measure to lower the risk of skin cancer. Following a low-cholesterol diet lowers the individual's risk of developing atherosclerotic plaque. Rest is important in maintaining homeostasis but has no real impact on neuropathies.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

170. 2. The interpreter may have been delayed. Therefore, the nurse's best action would be to reschedule the child's appointment when the interpreter can be scheduled as well. Because the mother does not speak English, there is no point in examining the infant because history information is needed and most likely would be too difficult to obtain. Asking the mother to stay longer is rude to her. Also, doing so would probably be difficult because of the communication gap. If the interpreter is delayed, paging one more time will not help.

 CN: Management of care; CL: Synthesize

171. 1. The client who is on a progressive exercise program at home after a myocardial infarction should be taught to monitor the pulse rate. The pulse rate can be expected to increase with exercise, but exercise should not be increased if the pulse rate increases more than about 25 bpm from baseline or exceeds 100 to 125 bpm. The client should also be taught to decrease exercise if chest pain or dyspnea occur.

 CN: Basic care and comfort; CL: Analyze

172. 1. The nurse's response fails to identify the meaning in what the client has said. The nurse needs to explore the client's statement about hating God for that flood because the meaning of the client's statement is unclear. Also, clichés such as, “Don't feel that way,” are not helpful because they ignore the client's feelings and his interpretation of the situation in which he finds himself. Explaining to the client why he may think as he does (offering a rationale) is inappropriate. The nurse's response fails to identify the meaning in what the client has said and is not supportive. There is no evidence that the client is solving his problems.

 CN: Psychosocial integrity; CL: Analyze

173. 3. The client who should be assessed first is the multigravid client who has been in labor for 8 hours and whose cervix is 8 cm dilated at 1+ station with contractions every 3 to 4 minutes. A multigravid client typically has a shorter labor than a primigravid, and this client's station is 1+, which means that birth of the fetus is imminent.

 CN: Management of care; CL: Synthesize

174. 1. The nurse should first obtain the blood glucose level and then contact the physician and clarify whether the client's usual insulin dose should be given before surgery; having the blood glucose level is objective information that the physician may need to know before making a final decision as to the insulin dosage. The nurse should not assume that the usual insulin dose is to be given. It is not appropriate for the nurse to defer decision-making on this issue until after the surgery.

 CN: Reduction of risk potential; CL: Synthesize

175. 4. Immediately after chest tube removal, a petrolatum gauze is placed over the wound and covered with a dry sterile dressing. This serves as an airtight seal to prevent air leakage or air movement in either direction. Bandages or straps are not applied directly over wounds. Mesh gauze allows air movement.

 CN: Management of care; CL: Apply

176. 4. By asking the client to tell more about how she is feeling, the nurse is not making any assumptions about what is troubling the client. The nurse should acknowledge the client's feelings and encourage her to discuss them. Saying that this situation must be frustrating involves assumptions by the nurse about why the client is crying and is not a therapeutic response. Asking how long the client has been unable to comb her hair takes the focus off her feelings and inhibits therapeutic communication. Inquiring why the client's husband hasn't helped

insinuates that the husband is not helping enough, which is inappropriate, takes the focus off the client's feelings, and inhibits therapeutic communication.

CN: Psychosocial integrity; CL: Synthesize

177. 3. Encouraging the client to talk about why she is here and about her feelings may reveal more information about what led her to come to the group and what led to her diagnosis. It also provides the nurse with valuable information needed to develop an appropriate plan of care. The comment that the client sounds angry presumes what the client is feeling and asks her to talk about her husband. The focus here should be on the client, not the husband. Telling the client that she will like coming to group imposes the nurse's view onto the client. The statement stresses that the group is fun instead of giving its therapeutic value. Having the client tell the nurse something about the cause of her bulimia ignores the client's original statement. Additionally, this statement requires the client to have insight into the cause of her disease, which may not be possible at this time. Also, it may be too early in the relationship to discuss the disorder.

CN: Psychosocial integrity; CL: Synthesize

178. 2. There is a direct interaction between the effects of insulin and those of beta blockers. The nurse must be aware that there is a potential for increased hypoglycemic effects of insulin when a beta blocker is added to the client's medication regimen. The client's blood sugar should be monitored. Ketoacidosis occurs in hyperglycemia. Although a decrease in the incidence of ketoacidosis could occur when a beta blocker is added, the direct result is an increase in the hypoglycemic effect of insulin.

CN: Pharmacological and parenteral therapies; CL: Apply

179. 3. Commonly, when a child appears better, the parents stop the medication. Unfortunately, the infection remains. Therefore, the nurse needs to explain that all of the medication must be administered to clear up the infection. Explaining why the medicine should be continued is more helpful to parents than saying it needs to be given.. Telling the parent that stopping the medication is not what is best for the child implies blame and is condescending.

CN: Pharmacological and parenteral therapies; CL: Synthesize

180. 3. The client is positioned correctly in the side-lying position. The pillows support the client's joints and do not cause unnecessary pressure on the joints or skin. It is not necessary to add another pillow under the arm or to elevate the head of the bed. The nurse should assess the client's skin for signs of breakdown, particularly at the elbows, back, hips, and heels where there were

pressure points from the position in which the client was previously lying.

CN: Reduction of risk potential; CL: Evaluate

181. 2. The serum cholesterol is within normal range for this client indicating the medication is effective. Since the cholesterol levels are within normal limits, it is likely that the client is taking the medication and asking may indicate the nurse has doubts or mistrusts that the client is taking the medication. The client does not need to change the diet at this point. Hemoglobin and hematocrit are not affected by simvastatin; since liver damage is a side effect of simvastatin, the nurse could review the liver function studies.

CN: Pharmacologic and parenteral therapies; CL: Synthesize

182. 2. Following crush injury, serum potassium rises to high levels. Sodium polystyrene sulfonate (Kayexalate) is a potassium binding resin. The resin combines with potassium in the colon and is then eliminated, and serum potassium levels should come back to normal. Normal serum potassium is 3.5 to 5.3. Weak, irregular pulse and tall peaked T waves on ECG are signs of hyperkalemia, and muscle weakness is a sign of hypokalemia.

CN: Pharmacological and Parenteral Therapies; CL: Evaluate

183. 1. An alternative or additional method of birth control must be used since oxcarbazepine (Trileptal) reduces the effectiveness of oral contraceptives. Higher doses of oral contraceptives will not help in achieving this purpose, but the client needs additional or alternative method of birth control. The client does not need advice about when to start her family. A side effect of Oxcarbazepine (Trileptal) may be weight gain, but it is typically gradual.

CN: Pharmacological and Parenteral Therapies; CL: Apply

184. 4. Hemodialysis clients have their protein requirements individually tailored according to their postdialysis weight. The protein requirement is 1.0 to 1.2 g/kg body weight per day. Hence, for a 59-kg weight, the amount of protein will be 59 to 70 g/day. Sodium should be restricted to 3 g/day. The client should obtain sufficient calories; if calories are not supplied in adequate amount, the body will use tissue protein for energy, which will lead to a negative nitrogen balance and malnutrition. Fluid intake needs to be restricted. The fluid amount is restricted to 500 to 700 mL plus the urine output.

CN: Pharmacological and parenteral therapies; CL: Synthesize.

185. 3. This client is exhibiting behaviors and symptoms associated with hyponatremia caused by water intoxication; the nurse would expect to find confirmation of a low serum sodium level by checking the electrolyte levels. The

nurse would expect this client's serum osmolality and urine specific gravity to be low, not high. The platelet count is not relevant as there is no correlation between sodium levels and platelet counts.

 CN: Physiological adaptation; CL: Analyze

186. 3. The woman is at risk for placental abruption due to her recent car accident. Symptoms of a placental abruption include unrelenting pain and a rigid boardlike abdomen. She may or may not have vaginal bleeding. In contrast, labor contractions are intermittent. The priority action by the nurse should be to ensure this client is further evaluated by her health care provider. Subsequent actions could include assisting with pain control measures, assessing contractions, and checking cervical dilation.

 CN: Management of care; CL: Analyze

187. 2. The parent's lament of stress and grief and the adolescent's behavior and drug use could be preludes to suicide, especially since another member of the family succeeded in suicide. Suicide attempts are more likely in families in which there has been a previous suicide attempt or suicide death, especially for young people. Though the family's emotional states are important, one is not more important than the other. Obviously, the parent's ability to emotionally support the adolescent in this crisis has been comprised, but the safety of both supersedes this concern.

 CN: Safety and infection control; CL: Analyze

188. 1, 3, 4, 5. Child molesters prey on lonely children or those who spend a lot of time at home alone due to a working parent. They initially show interest and assist the child and family such as providing rides, money, and homework help. Once trust is established, molesters push for a more sexual relationship, which they justify by pointing out what they have done to help the child. If the child tries to stop the sexual interaction or appears ready to tell someone, molesters will use threats to maintain the secret. Though some child molesters have had difficult childhoods in which they may have been molested, having them recognize that is not enough to keep them from offending again.

 CN: Safety or psychosocial integrity; CL: Apply

189. 1. The nurse must use at least two ways to identify clients. This is done to make sure that each client gets the correct medication/s and/or treatment/s. Although all of the remaining actions need to be done, none of the others would be the first action.

 CN: Physiological adaptation; CL: Apply

190. 20, Low Risk: This client's only risk factor is IV access, making this client low risk for a fall. The nurse must remember to revaluate a client's risk for fall after any change in condition, upon transfer to another unit within the hospital or after a fall. In most acute care facilities, a fall risk is completed at least every 24 hours if not every shift.

 CN: Safety and infection control; CL: Evaluate

191. 3, 4, 5. The client has a Stage II pressure ulcer. The nurse should take measures to relieve the pressure, treat the local infection, and protect the wound. The nurse should keep the ulcer covered with a protective dressing. The client should turn every 2 hours and use an alternating-pressure mattress to relieve pressure on the buttocks. The head of the bed should be elevated no more than 30 degrees. All wounds have bacteria, and obtaining frequent cultures (unless prescribed otherwise) is not necessary.

 CN: Safety and infection control; CL: Synthesize

TEST 2: Comprehensive

1. The unit secretary who transcribes the physicians' prescriptions asks the nurse to interpret an illegible prescription. The nurse should:

☐ **1.** Interpret the prescription according to the client's previous medication record.
☐ **2.** Clarify the prescription with the pharmacist.
☐ **3.** Clarify the prescription by calling the physician.
☐ **4.** Clarify the client's medications with the client's family.

2. A client with cholecystitis is taking propantheline bromide (Pro-Banthine). The expected outcome of this drug is:

☐ **1.** Increased bile production.
☐ **2.** Decreased biliary spasm.
☐ **3.** Absence of infection.
☐ **4.** Relief from nausea.

3. The nurse refers the parents of a child with cystic fibrosis to an organization that helps families with children who have this disease. Such organizations are especially beneficial for parents by helping them:

☐ **1.** Find tutors to educate their children at home.
☐ **2.** Obtain genetic counseling.
☐ **3.** Meet with other parents of children with cystic fibrosis for mutual support.
☐ **4.** Obtain financial assistance to purchase medications for their children.

4. After a bronchoscopy with biopsy, the nurse assesses the client. Which of the following signs should be reported immediately to the physician?

☐ **1.** Green sputum.
☐ **2.** Dry cough.
☐ **3.** Hemoptysis.
☐ **4.** Laryngeal stridor.

5. A client tells the nurse that “the hospital food is horrible.” Which of the following is the **most** appropriate response by the nurse?

☐ **1.** “The staff is doing the best they can to cook in such large quantities.”
☐ **2.** “I'll report this to the physician.”
☐ **3.** “Would you like to speak with the dietitian about the food and meal

selection?”

☐ **4.** “I don't like the hospital cafeteria food either.”

6. The nurse must be aware that adverse drug reactions in the elderly client may be underestimated because:

☐ **1.** Adverse reactions rarely have an atypical presentation.
☐ **2.** Cognitive impairment is an expected finding in the elderly client.
☐ **3.** Physical or psychological symptoms are attributed to the effects of aging.
☐ **4.** Excess sedation is difficult to assess in the elderly client.

7. An elderly man experiences a thrombotic cerebrovascular accident and subsequent flaccid hemiplegia of the right side. When planning care for this client, rehabilitation begins:

☐ **1.** As soon as anticoagulant therapy is started.
☐ **2.** When the client is admitted to the hospital.
☐ **3.** When the client can first work cooperatively with health care personnel.
☐ **4.** As directed by the physical therapist.

8. An unmarried pregnant teenager tells the nurse that she is undecided about having an abortion or giving the baby up for adoption. The **best** response for the nurse to offer is which of the following?

☐ **1.** “You should give the baby up so that it can have a better home and opportunities.”
☐ **2.** “Research studies show that babies do better with their natural mothers.”
☐ **3.** “It must be a difficult decision. What have you thought about so far?”
☐ **4.** “Why don't you try keeping the baby. You can always give it up for adoption later.”

9. When administering blood, the nurse must check the name on the label of the blood with the name on the client's:

☐ **1.** Wristband with a family member present.
☐ **2.** Wristband in the presence of another nurse.
☐ **3.** Medical chart with the unit clerk.
☐ **4.** Medication administration record with the pharmacist.

10. A client is diagnosed with syndrome of inappropriate antidiuretic hormone (SIADH). The nurse should assess the client for which alteration in fluid and electrolyte balance?

☐ **1.** Increased osmolality of the plasma.
☐ **2.** Decreased serum sodium level.
☐ **3.** Increased urine output.
☐ **4.** Decreased blood pressure.

11. A client is admitted to the emergency department with crushing chest injuries sustained in a car accident. Which of the following signs indicates a possible pneumothorax?

☐ **1.** Cheyne-Stokes respirations.
☐ **2.** Increased fremitus.
☐ **3.** Diminished or absent breath sounds on the affected side.
☐ **4.** Decreased sensation on the affected side.

12. Which of the following statements by a client taking valproic acid for bipolar disorder indicates that further teaching about this medication is necessary?

☐ **1.** “I need to take the pills at the same time each day.”
☐ **2.** “I can chew the pills if necessary.”
☐ **3.** “I can take the pills with food.”
☐ **4.** “I need to call my doctor if I start bruising easily.”

13. A nurse is obtaining the history of an infant with suspected acute otitis media. What should the nurse ask the parent about?

☐ **1.** Position of the infant when taking a bottle.
☐ **2.** Covering of the infant's ears when out in the cold.
☐ **3.** Thorough drying of the infant's ears after a bath.
☐ **4.** Immunization status of the infant.

14. A client is having elective surgery under general anesthesia. Who is responsible for obtaining the informed consent?

☐ **1.** The nurse.
☐ **2.** The surgeon.
☐ **3.** The anesthesiologist.
☐ **4.** The nurse anesthetist.

15. The family of an elderly client with terminal cancer inquires about hospice services. The nurse explains that hospice care:

☐ **1.** Focuses only on the needs of the client.
☐ **2.** Can only be provided in the inpatient setting.
☐ **3.** Is staffed exclusively by professional health care workers.
☐ **4.** Focuses on supportive care for the client and family.

16. A primigravid client at 8 weeks' gestation tells the nurse that she doesn't like milk. To ensure that the client consumes an adequate intake of milk products, the nurse should instruct the client that an 8-oz (250-mL) glass of milk is equal to which of the following?

☐ **1.** 2 tablespoons (30 mL) of Parmesan cheese.
☐ **2.** 1½ cup (375 mL) of a milkshake.

☐ **3.** 1½ to 2 slices of presliced cheddar cheese.
☐ **4.** ½ cup (125 mL) of cottage cheese.

17. A primigravid client at 35 weeks' gestation is scheduled for a biophysical profile. After instructing the client about the test, which of the following, if stated by the client as one of the parameters of this test, indicates effective teaching?
☐ **1.** Amniotic fluid volume.
☐ **2.** Placement of the placenta.
☐ **3.** Amniotic fluid color.
☐ **4.** Fetal gestational age.

18. When caring for a child who has been receiving long-term steroid therapy, the nurse should assess the child for:
☐ **1.** Usual behavior and temperament.
☐ **2.** Loss of weight from baseline.
☐ **3.** Development of truncal obesity.
☐ **4.** Demonstration of a growth spurt.

19. The nurse manager has assigned a nurse as the circulating nurse for a surgical abortion. The nurse is Roman Catholic and wishes to refuse to participate in an abortion. The nurse manager of the operating room should:
☐ **1.** Require the nurse to do this assignment.
☐ **2.** Change the assignment, and record the behavior on the nurse's evaluation.
☐ **3.** Change the assignment without comment.
☐ **4.** Change the assignment to circulate, but have the nurse prepare the equipment.

20. An 86-year-old has few health problems, performs self-care, plays cards, and talks about “the good old days.” The client wants to make “final” arrangements, such as completing an advance directive and planning and paying for a funeral and burial. The nurse determines that the client:
☐ **1.** Is depressed and should be watched for further signs of depression.
☐ **2.** Is responding in an age-appropriate manner.
☐ **3.** Is potentially suicidal and should be placed on suicide precautions and seen by a psychiatrist.
☐ **4.** Has a premonition about dying soon.

21. A client is taking phenytoin (Dilantin) as an antiepileptic medication. The nurse should instruct the client to obtain:
☐ **1.** Increased iron.
☐ **2.** Increased calcium.
☐ **3.** Frequent dental examinations.

☐ **4.** Frequent eye examinations.

22. The nurse should establish baseline data on a client who is starting on long-term gentamicin sulfate (Garamycin) therapy. Which of the following is **least** important for assessment screening in this client?

☐ **1.** Visual acuity.
☐ **2.** Vestibular function.
☐ **3.** Renal function.
☐ **4.** Auditory function.

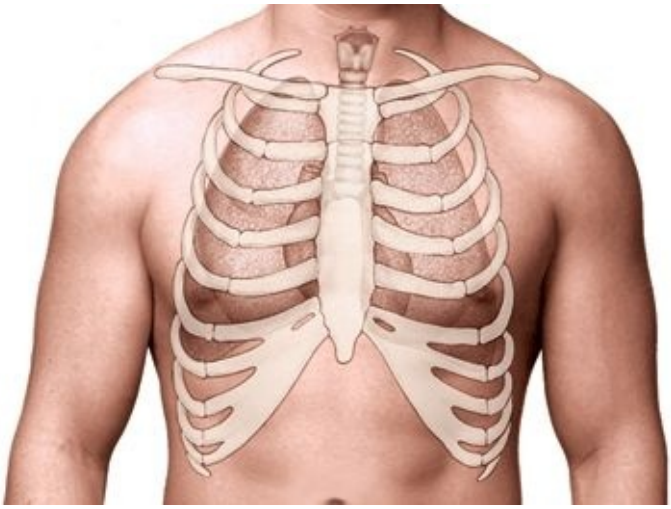
23. A hospitalized 5-year-old is pulseless, and after verifying the child is not breathing, the nurse begins chest compressions. The nurse should apply pressure:

☐ **1.** On the lower sternum with the heel of one hand.
☐ **2.** Midway on the sternum with the tips of two fingers.
☐ **3.** Over the apex of the heart with the heel of one hand.
☐ **4.** On the upper sternum with the heels of both hands.

24. When developing a nutritional plan for a child who needs to increase protein intake, the nurse should suggest which of the following foods? Select all that apply.

☐ **1.** Bacon.
☐ **2.** Cooked dry beans.
☐ **3.** Peanut butter.
☐ **4.** Yogurt.
☐ **5.** Apple.

25. The nurse is auscultating S_1 and S_2 in a client. Identify the area where the nurse should hear S_1 the loudest.



26. The nurse instructs a client with coronary artery disease in the proper use of nitroglycerin (Nitrostat). At the onset of chest pain, the client should:

☐ **1.** Call 911 when three nitroglycerin tablets taken every 5 minutes are ineffective.

☐ **2.** Call 911 when five nitroglycerin tablets taken every 5 minutes are ineffective.

☐ **3.** Take three nitroglycerin tablets, 10 minutes apart, and call 911.

☐ **4.** Go to the emergency department if three nitroglycerin tablets are ineffective.

27. A diet high in which of the following food substances contributes to increases in serum cholesterol?

☐ **1.** Polyunsaturated fat.

☐ **2.** Saturated fat.

☐ **3.** Monounsaturated fat.

☐ **4.** Phospholipids.

28. During the health history, a client bluntly states, “I think I'm better off dead.” The **best** response by the nurse is which of the following?

☐ **1.** “Has a family member ever committed suicide?”

☐ **2.** “When did these feelings begin?”

☐ **3.** “Do you have someone at home to help you?”

☐ **4.** “Are you thinking about suicide?”

29. A client is taking methotrexate for severe rheumatoid arthritis. The nurse instructs the client that it will be necessary to monitor:

☐ **1.** Serum glucose.

☐ **2.** Serum electrolytes.

☐ **3.** Complete blood count (CBC) with differential and platelet count.

☐ **4.** Sedimentation rate.

30. Which of the following meals would be appropriate for the child with osteomyelitis to choose?

☐ **3.** Beef and bean burrito with cheese, carrot and celery sticks, and an orange.

☐ **2.** Buttered wheat bread, cream of broccoli soup, lettuce salad with ranch dressing, and an apple.

☐ **3.** Potato soup; bacon, lettuce, and tomato sandwich; and a peach.

☐ **4.** Tomato soup, grilled cheese sandwich, and banana.

31. An elderly client is constipated and tells the nurse that this has not happened before. The **best** response for the nurse to make is which of the following?

☐ **1.** “Constipation is an expected problem at your age.”

☐ **2.** “You need to eat more fiber.”
☐ **3.** “You need to drink more water.”
☐ **4.** “The new onset of constipation may be a sign of a more serious problem.”

32. A nurse is interviewing a client who will begin rehabilitation for alcohol dependency. Which approach by the nurse is **most** helpful to the client before starting the program?
☐ **1.** “You need to be very serious about this program.”
☐ **2.** “You need to want to be alcohol-free before we can help you.”
☐ **3.** “This program requires you to do a lot of hard work.”
☐ **4.** “We'll help you be successful so that you can stay alcohol-free.”

33. A client who has been newly diagnosed with type 1 diabetes asks the nurse, “Why do I have to take two shots of insulin? Shouldn't one shot be enough?” The **best** response for the nurse to make is which of the following?
☐ **1.** “A single shot of long-acting insulin would be preferable.”
☐ **2.** “You might be able to change to oral medications soon.”
☐ **3.** “Two shots will give you better control and decrease complications.”
☐ **4.** “I'll ask the physician to change your insulin schedule.”

34. The nurse reviews the peak and trough serum levels from a client who is receiving gentamicin sulfate (Garamycin) in order to:
☐ **1.** Adjust the dosage to the therapeutic range.
☐ **2.** Avoid allergic reactions.
☐ **3.** Prevent side effects.
☐ **4.** Reach therapeutic levels more quickly.

35. A client with a history of type 1 diabetes mellitus and chronic obstructive pulmonary disease should have which of the following immunizations?
☐ **1.** Influenza.
☐ **2.** Hepatitis A.
☐ **3.** Measles-mumps-rubella.
☐ **4.** Varicella.

36. A parent tells the nurse that their 8-month-old infant is anxious. Which of the following suggestions by the nurse is **most** appropriate to help the parent lessen anxiety about the infant?
☐ **1.** Limit holding the infant to feeding times.
☐ **2.** Talk quietly to the infant while awake.
☐ **3.** Play music in his room for most of the day and night.
☐ **4.** Have a close friend keep the infant for a few days.

37. The parent of a 2-week-old infant brings the child to the clinic for a checkup. The parent expresses concern about the baby's breathing because the infant breathes quickly for a while and then breathes slowly. The nurse interprets this finding as an indication of which of the following?

☐ **1.** A normal pattern in infants of this age.
☐ **2.** The need for an apnea monitor.
☐ **3.** A need for close monitoring for the parent.
☐ **4.** The need for a chest radiograph.

38. Which of the following complications is associated with a tracheostomy?

☐ **1.** Decreased cardiac output.
☐ **2.** Damage to the laryngeal nerve.
☐ **3.** Pneumothorax.
☐ **4.** Acute respiratory distress syndrome.

39. The nurse who is caring for a client with type 1 diabetes mellitus should use which of the following to determine how well the insulin, diet, and exercise are balanced?

☐ **1.** Fasting serum glucose level.
☐ **2.** 1-week dietary recall.
☐ **3.** Home log of blood glucose levels.
☐ **4.** Glycosylated hemoglobin level.

40. The nurses have instituted a falls prevention program. Which of the following strategies will have the **highest** likelihood of preventing falls?

☐ **1.** Putting a falls risk sign on the clients' doors.
☐ **2.** Having the client wear a color-coded armband.
☐ **3.** Making rounds of the unit and clients' rooms.
☐ **4.** Keeping all beds in low position.

41. A client is receiving a unit of packed red blood cells. Before the transfusion started, the client's blood pressure was 90/50 mm Hg, pulse rate 100 bpm, respirations 20 breaths/min, and temperature 98°F (36.7°C). Fifteen minutes after the transfusion starts, the client's blood pressure is 92/54 mm Hg, pulse 100 bpm, respirations 18 breaths/min, and temperature is 101.4°F (38.6°C). The nurse should **first**:

☐ **1.** Stop the transfusion.
☐ **2.** Raise the head of the bed.
☐ **3.** Obtain a prescription for antibiotics.
☐ **4.** Offer the client a cool washcloth.

42. For which of the following findings in a client receiving opioid epidural

analgesia should the nurse notify the physician? Select all that apply.

☐ **1.** Blood pressure of 80/40 mm Hg, baseline blood pressure of 110/60 mm Hg.
☐ **2.** Respiratory rate of 14 breaths/min, baseline respiratory rate of 18 breaths/min.
☐ **3.** Report of crushing headache.
☐ **4.** 1.5 mL of blood aspirated from the catheter before the bolus injection.
☐ **5.** Pain rating of 3 on a scale of 1 to 10.

43. Which of the following dietary strategies **best** meets the nutritional needs of a client with acquired immunodeficiency syndrome (AIDS)?

☐ **1.** Tell the client to eat large meals frequently.
☐ **2.** Encourage megadoses of nutritional supplements.
☐ **3.** Instruct the client to cook foods thoroughly and adhere to safe food-handling practices.
☐ **4.** Tell the client to prepare food in advance and leave it out to eat small amounts throughout the day.

44. Before an incisional cholecystectomy is performed, the nurse instructs the client in the correct use of an incentive spirometer. Why is incentive spirometry essential after surgery in the upper abdominal area?

☐ **1.** The client will be maintained on bed rest for several days.
☐ **2.** Ambulation is restricted by the presence of drainage tubes.
☐ **3.** The operative incision is near the diaphragm.
☐ **4.** The presence of a nasogastric tube inhibits deep breathing.

45. The nurse is examining a 6-week-old dark-skinned infant. There are large spots of deep blue pigmentation across the infant's buttocks. The nurse should identify this sign as characteristic of:

☐ **1.** Vascular disease.
☐ **2.** Telangiectatic nevi.
☐ **3.** Infant milia.
☐ **4.** Mongolian spots.

46. A nulliparous client has been given a prescription for oral contraceptives. Which of the following should the nurse instruct the client to report to the health care provider immediately?

☐ **1.** Blurred vision.
☐ **2.** Nausea.
☐ **3.** Weight gain.
☐ **4.** Mild headache.

47. A client experienced a pneumothorax after the placement of a central

venous pressure line. Which of the following supports a diagnosis of pneumothorax?

☐ **1.** Sudden, sharp pain on the affected side.
☐ **2.** Tracheal deviation toward the affected side.
☐ **3.** Bradypnea and elevated blood pressure.
☐ **4.** Presence of crackles and wheezes.

48. A client is experiencing a flashback from the use of lysergic acid diethylamide. The nurse should:

☐ **1.** Confront the client's misperceptions.
☐ **2.** Reassure the client while presenting reality.
☐ **3.** Seclude the client until the flashback ends.
☐ **4.** Challenge the client's unrealistic statements.

49. The nurse should dispose of a used needle and syringe by:

☐ **1.** Cutting the needle at the hilt in a needle cutter before disposing of it in the universal precaution container in the client's room.
☐ **2.** Placing uncapped, used needles and syringes immediately in the universal precaution container in the client's room.
☐ **3.** Recapping the needle and placing the needle and syringe in the universal precaution container in the client's room.
☐ **4.** Separating the needle and syringe and placing both in the universal precaution container in the client's room.

50. The nurse is planning a health promotion education session for a community health fair. The nurse reviews health data for the community (see below) prior to planning the session. To develop a program which is appropriate for the residents of this community and is cost-effective, the nurse should plan to do which of the following? Select all that apply.

☐ **1.** Focus on information about preventing heart disease.
☐ **2.** Appeal to college graduates.
☐ **3.** Present the program in Spanish and English.
☐ **4.** Develop content that is culturally appropriate for members of all ethnic/racial groups in the community.
☐ **5.** Provide printed materials for each participant.

Deaths by Cause	
Deaths by accident	28
Deaths by homicide	2
Deaths by heart disease	238
Deaths by suicide	12
Deaths by cancer	203
Deaths by motor vehicle accident	10

Educational Attainment	
High school dropouts	6,604
No high school diploma	101,596
High school diploma only	163,995
High school diploma or more	451,863
Some college	147,330
Associate degree or more	171,410
Bachelor degree or more	140,550

Race/Ethnicity	
Black	54,083
Native American/First Nations	294
Asian	2,047
Caucasian	78,122
Mexican	459
Multiracial	7,073

51. An 80-year-old client is admitted with nausea and vomiting. The client has a history of heart failure and is being treated with digoxin (Lanoxin). The client has been nauseated for a week and began vomiting 2 days ago. Laboratory values indicate hypokalemia. Because of these clinical findings, the nurse should assess the client carefully for signs of which of the following conditions?

☐ **1.** Chronic renal failure.
☐ **2.** Exacerbation of heart failure.
☐ **3.** Digoxin toxicity.
☐ **4.** Metabolic acidosis.

52. The nurse instructs the client with osteoporosis that food products high in calcium include:

☐ **1.** Rice.
☐ **2.** Broccoli.
☐ **3.** Apples.
☐ **4.** Meat.

53. A woman is using progestin injections (Depo-Provera) for contraception. The nurse instructs the client to return for an appointment in:

☐ **1.** 1 month.
☐ **2.** 3 months.
☐ **3.** 4 months.
☐ **4.** 6 months.

54. A client exhibits increased restlessness. Arterial blood gas results are pH, 7.52; partial pressure of carbon dioxide, 38 mm Hg (5.1 kPa); bicarbonate, 34 mg/L (34 mmol/L). The nurse should plan care based on the fact that these findings indicate which of the following acid-base imbalances?

☐ **1.** Respiratory alkalosis.
☐ **2.** Respiratory acidosis.
☐ **3.** Metabolic acidosis.
☐ **4.** Metabolic alkalosis.

55. While the nurse is caring for a multigravid client at 39 weeks' gestation in active labor whose cervix is dilated to 7 cm and completely effaced at +1 station, the client says, “I need to push!” Which of the following should the nurse do **next**?

☐ **1.** Turn the client to her left side.
☐ **2.** Tell her to push when she has the urge.
☐ **3.** Have her pant quickly during the contraction.
☐ **4.** Tell her to focus on an object in the room to relax.

56. When teaching a client with chronic renal failure who is taking antibiotics about signs and symptoms of potential nephrotoxicity to report, the nurse should encourage the client to promptly report which of the following changes in the color of the urine? Select all that apply.

☐ **1.** Straw-colored.
☐ **2.** Cloudy.
☐ **3.** Smoky.
☐ **4.** Pink.

57. The nurse is assessing a child with suspected juvenile hypothyroidism. Which of the following should the nurse expect this child to manifest?

☐ **1.** Short attention span and weight loss.
☐ **2.** Weight loss and flushed skin.
☐ **3.** Rapid pulse and heat intolerance.
☐ **4.** Dry skin and constipation.

58. A 10-year-old diagnosed with attention deficit hyperactivity disorder (ADHD) has been switched from a stimulant to atomoxetine (Strattera) 40 mg

two times a day. The nurse is instructing the client and the mother about the change in medication. Which statement indicates that the client's mother needs further education about the medication? Select all that apply.

☐ **1.** “I have to give her both doses before lunch.”
☐ **2.** “I'll have to make sure she's gaining weight appropriately.”
☐ **3.** “She may have nausea or dizziness for 1 or 2 months.”
☐ **4.** “If she has mood swings, I should call her psychiatrist.”
☐ **5.** “She can't take monoamine oxidase inhibitors while on Strattera.”
☐ **6.** “If her ADHD symptoms don't improve in 2 to 3 weeks, I should stop the Strattera.”

59. Which of the following will be most effective in reducing a client's fluid volume excess?

☐ **1.** Low-sodium diet.
☐ **2.** Monitoring serum electrolytes daily.
☐ **3.** Restricting fluid intake.
☐ **4.** Elevation of the client's feet.

60. The nurse observes a darkish blue pigment on the buttocks and back of an infant of African descent. Which of the following actions is **most** appropriate?

☐ **1.** Ask the obstetrician to assess the child.
☐ **2.** Assess the child for other areas of cyanosis.
☐ **3.** Document this observation in the child's record.
☐ **4.** Advise the mother that laser therapy is needed.

61. During a physical examination, the nurse observes a copper bracelet on a client's wrist. The client states that she is wearing it to treat her arthritis. The nurse should:

☐ **1.** Recognize that the client is wearing a protective object she believes wards off illness.
☐ **2.** Inform the client that this is a not a helpful practice and ask her to remove the bracelet.
☐ **3.** Tell the client that wearing the bracelet is a form of quackery and not to use the bracelet as a treatment.
☐ **4.** Continue to wear the copper bracelet because this is a medically supported treatment for arthritis.

62. The heart rate of a newly born term neonate is regular at 142 bpm. Which of the following should the nurse do **next**?

☐ **1.** Notify the neonate's pediatrician.
☐ **2.** Check for the presence of cyanosis.

☐ **3.** Assess the heart rate again in 3 hours.
☐ **4.** Document this as a normal neonatal finding.

63. The fetus of a multigravid client at 38 weeks' gestation is determined to be in a frank breech presentation. The nurse describes this presentation to the client as which of the following fetal parts coming in contact with the cervix?
☐ **1.** Buttocks.
☐ **2.** Head.
☐ **3.** Both feet.
☐ **4.** Shoulder.

64. The therapeutic effects of desmopressin nasal spray (DDAVP) are obtained when the client no longer has:
☐ **1.** Polydipsia.
☐ **2.** Nasal congestion.
☐ **3.** Headache.
☐ **4.** Blurred vision.

65. The nurse advises a 42-year-old client to have a screening mammogram. The client asks why this is necessary since she performs a breast self-examination (BSE) monthly. The nurse's **best** response is:
☐ **1.** “All women over 35 should have an annual mammogram.”
☐ **2.** “A mammogram can identify breast cancer before it's detectable by BSE.”
☐ **3.** “Most women don't perform BSE thoroughly enough to detect cancer.”
☐ **4.** “A mammogram can detect other endocrine abnormalities as well.”

66. A client is recovering from an infected abdominal wound. Which of the following foods should the nurse encourage the client to eat to support wound healing and recovery from the infection?
☐ **1.** Chicken and orange slices.
☐ **2.** Cheeseburger and french fries.
☐ **3.** Cheese omelet and bacon.
☐ **4.** Gelatin salad and tea.

67. The nurse teaches the client with iron deficiency anemia that food sources with high iron content include:
☐ **1.** Cheese.
☐ **2.** Squash.
☐ **3.** Eggs.
☐ **4.** Beef.

68. The mother of a toddler diagnosed with iron deficiency anemia asks what foods she should give her child. The nurse should evaluate the teaching as

successful when the mother later reports that she feeds the toddler which of the following?

☐ **1.** Milk, carrots, and beef.
☐ **2.** Raisins, chicken, and spinach.
☐ **3.** Beef, lettuce, and juice.
☐ **4.** Eggs, cheese, and milk.

69. A toddler admitted in respiratory distress keeps pulling at the oxygen mask, trying to remove it. The nurse should do which of the following? Select all that apply.

☐ **1.** Restrain the child.
☐ **2.** Have the parent read to the child.
☐ **3.** Administer a sedative.
☐ **4.** Encourage the parent to hold the child.
☐ **5.** Tell the child the mask will help him breathe better.
☐ **6.** Ask the parent to leave the child's bedside.

70. Four hours after a cast has been applied for a fractured ulna, the nurse assesses that the client's fingers are pale and cool and capillary refill is delayed for 4 seconds. How should the nurse interpret these findings?

☐ **1.** Nerve impairment is developing in the fingers.
☐ **2.** Arterial blood supply to the fingers is decreased.
☐ **3.** Venous stasis is occurring in the fingers.
☐ **4.** The finding is normal for this recovery period.

71. The nurse is developing a plan of care for a client who has joint stiffness due to rheumatoid arthritis. Which of the following interventions is **most** effective in relieving stiffness?

☐ **1.** A warm shower before performing activities of daily living.
☐ **2.** Aspirin after activity to decrease inflammation.
☐ **3.** A 10-lb (4.5-kg) weight loss to limit stress on joints.
☐ **4.** Cold compresses to joints for 30 minutes to relieve stiffness.

72. The nurse walks into the room and finds that a client who has just had surgery is diaphoretic, appears to have no respirations, and has a barely palpable pulse. The nurse should **first**:

☐ **1.** Call a code.
☐ **2.** Open the airway.
☐ **3.** Start rescue breathing.
☐ **4.** Start cardiac compressions.

73. A client with obsessive-compulsive disorder washes the hands multiple times daily and is late for meals and milieu activities. Which of the following is

most appropriate for the nurse to do initially?

☐ **1.** Totally eliminate the client's ritual.
☐ **2.** Allow the client to decide whether to attend meals and activities.
☐ **3.** Inform the client that absence from meals and activities is not permitted.
☐ **4.** Remind the client about meal and activity times so that the ritual can be completed on time.

74. After discussing preconception needs with a nulliparous client of Asian descent, which of the following client statements indicates the need for further instruction?

☐ **1.** "I should take folic acid supplements before I get pregnant."
☐ **2.** "If I become pregnant, I can continue to eat sushi twice a week."
☐ **3.** "I should continue to steam my vegetables rather than cooking them for a long time."
☐ **4.** "Eating soy products can increase my protein levels once I'm pregnant."

75. A client with osteoarthritis purchased a copper bracelet to wear and tells the nurse that there is less pain now. Which response by the nurse is **most** appropriate?

☐ **1.** Tell the client to remove the bracelet because it does not have any therapeutic value.
☐ **2.** Warn the client not to spend any more money on quackery such as bracelets.
☐ **3.** Instruct the client to remove the bracelet because the copper in it can interfere with salicylate metabolism.
☐ **4.** Acknowledge that the client feels better, but encourage the client to continue with the prescribed therapy.

76. The client is started on simvastatin (Zocor) as a component of cholesterol management. Which of the following laboratory tests needs to be monitored while on this therapy?

☐ **1.** Complete blood count.
☐ **2.** Serum glucose.
☐ **3.** Total protein.
☐ **4.** Liver function tests.

77. A man of Chinese descent is admitted to the hospital with multiple injuries after a motor vehicle accident. His pain is not under control. The client states, "If I could be with my people, I could receive acupuncture for this pain." The nurse should understand that acupuncture in the Asian culture is based on the theory that it:

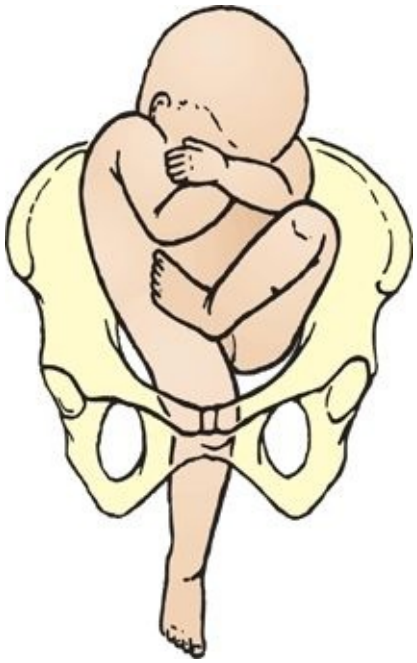
☐ **1.** Purges evil spirits.

☐ **2.** Promotes tranquility.
☐ **3.** Restores the balance of energy.
☐ **4.** Blocks nerve pathways to the brain.

78. A client is taking large doses of aspirin daily to treat rheumatoid arthritis. Which of the following side effects should the nurse instruct the client to report?
☐ **1.** Abdominal cramps.
☐ **2.** Tinnitus.
☐ **3.** Rash.
☐ **4.** Hypotension.

79. A client is transferred from the coronary care unit to the step-down unit. Which of the following should be included in the transfer report? Select all that apply.
☐ **1.** The client needs oxygen at 2 L/min.
☐ **2.** The client has a “do not resuscitate” prescription.
☐ **3.** The client uses the bedpan.
☐ **4.** The client has four grandchildren.
☐ **5.** The client has been in normal sinus rhythm for 6 hours.

80. The nurse is assessing fetal presentation in a multiparous client. The figure below indicates which of the following types of presentations?
☐ **1.** Frank breech.
☐ **2.** Complete breech.
☐ **3.** Footling breech.
☐ **4.** Vertex.



81. A multigravid client at 26 weeks' gestation with a history of pregnancy-induced hypertension (PIH) asks the nurse about traveling from North America to a village in India by airplane to visit her father, who wishes to see her before she gives birth. Which of the following responses by the nurse is **most** appropriate?

☐ **1.** "Air travel at this point in your pregnancy can lead to preterm labor."
☐ **2.** "You can travel by airplane as long as you take frequent walks during the trip."
☐ **3.** "You need to avoid traveling because of your history of PIH."
☐ **4.** "You'd be placing yourself and your fetus at risk for communicable diseases common in India."

82. A pregnant woman does not have funds to purchase adequate, nutritious food. She works part time at a low-wage job and has two other children. The nurse can refer the client to which of the following?

☐ **1.** Home-delivered meals.
☐ **2.** Neighbors who can provide food.
☐ **3.** The pregnant woman's employer.
☐ **4.** Food bank.

83. The nurse is caring for a client who has severe burns on the head, neck, trunk, and groin areas. Which position would be **most** appropriate for preventing contractures?

☐ **1.** High Fowler's.
☐ **2.** Semi-Fowler's.
☐ **3.** Prone.
☐ **4.** Supine.

84. The client sustained an open fracture of the femur from an automobile accident. For which of the following types of shock should the client be assessed?
☐ **1.** Cardiogenic.
☐ **2.** Hypovolemic.
☐ **3.** Neurogenic.
☐ **4.** Anaphylactic.

85. The client has various sensory impairments associated with type 1 diabetes. The nurse determines that the client needs further instruction when the client says:
☐ **1.** “I'll carefully test the temperature of my bathwater.”
☐ **2.** “I'll avoid kitchen activities.”
☐ **3.** “I'll avoid hot water bottles or heating pads.”
☐ **4.** “I'll inspect my skin daily for pressure points and injury.”

86. The nurse is providing discharge instructions to the client with peripheral vascular disease. Which of the following instructions should be included in the discussion with this client? Select all that apply.
☐ **1.** Avoiding prolonged standing and sitting.
☐ **2.** Limiting walking so as not to activate the “muscle pump.”
☐ **3.** Keeping extremities elevated on pillows.
☐ **4.** Keeping the legs in a dependent position.
☐ **5.** Using a heating pad to promote vasodilation.

87. A father tells the nurse that his adolescent son spends lots of time in his room, his grades are falling, and he has given away a few of his most favorite compact disks. Which of the following is the **most** appropriate action for the nurse?
☐ **1.** Give the father the telephone number for the local crisis hotline.
☐ **2.** Have the father take the adolescent to the nearest mental health outpatient facility now.
☐ **3.** Make a same-day appointment for the adolescent with his usual health care provider.
☐ **4.** Obtain more history information from the distraught father before making a decision.

88. A 7-year-old child is admitted to the hospital with acute rheumatic fever

with chorea-like movements. Which of the following eating utensils should the nurse remove from the meal tray?

☐ **1.** Fork.
☐ **2.** Spoon.
☐ **3.** Plastic cup.
☐ **4.** Drinking straw.

89. The nurse should prepare the client for which of the following during the immediate postoperative care after reversal of a colostomy? Select all that apply.

☐ **1.** Nasogastric (NG) tube attached to low intermittent suction.
☐ **2.** Administration of IV fluids.
☐ **3.** Daily measurement of abdominal girth.
☐ **4.** Calculation of intake and output every 8 hours.
☐ **5.** Assessment of vital signs every 6 hours.

90. A client's catheter is removed 4 days after a transurethral resection of the prostate (TURP). He is experiencing urinary dribbling. The nurse should do which of the following?

☐ **1.** Teach the client Kegel exercises.
☐ **2.** Obtain a urine culture and sensitivity analysis to screen for a urinary infection.
☐ **3.** Encourage voiding every hour to prevent dribbling.
☐ **4.** Inform him that the dribbling will stop after a few days.

91. An adolescent primigravid client at 26 weeks' gestation has gained 25 lb since becoming pregnant. Which of the following is the recommended amount of weight gain during the third trimester?

☐ **1.** 1 lb (0.45 kg) per week.
☐ **2.** 2 lbs (0.9 kg) per week.
☐ **3.** 7 lbs (3.2 kg per week).
☐ **4.** 5 to 6 lbs (2.3 to 2.7 kg) for the trimester.

The nurse is preparing to administer 0.1 mg of digoxin (Lanoxin) intravenously. Digoxin comes in a concentration of 0.5 mg/2 mL. How many milliliters should the nurse administer?

_____ mL.

93. The mother of a 2-month-old infant with colic states, “I don't know what to do anymore. She's up in the middle of the night crying all the time.” The nurse should tell the mother to:

☐ **1.** Walk the floor with the baby at night.
☐ **2.** Take the infant for a short drive in the car.

☐ **3.** Allow the infant to cry it out in her crib.
☐ **4.** Offer cereal to fill the baby's stomach.

94. After the application of an arm cast, the client has pain on passive stretching of the fingers, finger swelling and tightness, and loss of function. Based on these data, the nurse anticipates that the client may be developing which of the following?
☐ **1.** Delayed bone union.
☐ **2.** Compartment syndrome.
☐ **3.** Fat embolism.
☐ **4.** Osteomyelitis.

95. Which of the following is a priority for a client who has just had a myocardial infarction?
☐ **1.** Low-back training program.
☐ **2.** Risk modification education.
☐ **3.** Strength training program.
☐ **4.** Jogging exercise program.

96. While assessing a 4-day-old neonate born at 28 weeks' gestation, the nurse cannot elicit the neonate's Moro reflex, which was present 1 hour after birth. The nurse notifies the physician because this may indicate which of the following?
☐ **1.** Postnatal asphyxia.
☐ **2.** Skull fracture.
☐ **3.** Intracranial hemorrhage.
☐ **4.** Facial nerve paralysis.

97. After transurethral resection of the prostate, the nurse notices that the client's urine is bright red, has numerous clots, and is viscous. Which nursing action is **most** appropriate?
☐ **1.** Irrigate the catheter to remove clots.
☐ **2.** Milk the catheter tube vigorously.
☐ **3.** Increase the client's fluid intake.
☐ **4.** Assess vital signs and notify the surgeon.

98. The nurse is teaching the client about the appropriate use of lorazepam (Ativan) to manage anxiety. Which of the following statements indicates that the client understands the nurse's teaching?
☐ **1.** “I can take my medicine whenever I feel anxious.”
☐ **2.** “It's okay to double my dose if I need to.”
☐ **3.** “My medicine isn't for the everyday stress of life.”
☐ **4.** “It's safe to have a glass of wine while taking this medicine.”

99. The physician prescribes a maternal blood test for alpha fetoprotein for a nulligravid client at 16 weeks' gestation. When developing the teaching plan, the nurse bases the explanations on the understanding that this test is used to detect which of the following?

☐ **1.** Neural tube defects.
☐ **2.** Chromosomal anomalies.
☐ **3.** Inborn errors of metabolism.
☐ **4.** Lecithin-sphingomyelin ratio.

100. A client with end-stage cancer who is receiving chemotherapy tells her husband that she feels useless now and wants to die. Prioritize, starting with first priority, the following statements the nurse should make to the husband.

☐ **1.** “I will assess your wife to determine if she is suicidal.”
☐ **2.** “She may feel differently when her chemotherapy is completed.”
☐ **3.** “Thanks for telling me this; it must be scary to have her tell you this.”
☐ **4.** “Let's discuss what you can say to her that may help.”

101. A nursing assistant recorded a client's 6:00 AM blood glucose level as 126 (7 mmol/L) instead of 216 (12 mmol/L). The nursing assistant did not recognize the error until 9:00 AM but reported it to the nurse right away. The nurse should next:

☐ **1.** Reassign the nursing assistant to another client.
☐ **2.** Wait and observe the client for symptoms of hyperglycemia.
☐ **3.** Reprimand the nursing assistant for the error.
☐ **4.** Call the physician and complete an incident report.

102. A client recovering from an abdominal hysterectomy has pain in her right calf. The nurse should:

☐ **1.** Palpate the calf to note pain.
☐ **2.** Measure the circumference of both calves and note the difference.
☐ **3.** Have the client flex and extend her leg and note the presence of pain.
☐ **4.** Raise the right leg and lower it to detect changes in skin color.

103. The nurse is caring for an elderly client who has experienced a sensorineural hearing loss. The nurse anticipates that the client will exhibit which one of the following symptoms?

☐ **1.** Difficulty hearing high-pitched sounds.
☐ **2.** Problems with speaking clearly.
☐ **3.** Inability to assign meaning to sound.
☐ **4.** Vertigo when changing positions.

104. A client recently diagnosed with lung cancer tells the nurse that she has been having difficulty sleeping and is often preoccupied with thoughts about

how her life has changed. She says, “I wish my life could just go on the way it was.” Which of the following should the nurse discuss with the client **first**?

☐ **1.** Preparing a will.
☐ **2.** Managing insomnia.
☐ **3.** Understanding grief.
☐ **4.** Relieving anxiety.

105. The physician prescribes IV nalbuphine (Nubain) for a primigravid client in early active labor. After administering the drug, which of the following should the nurse do **first**?

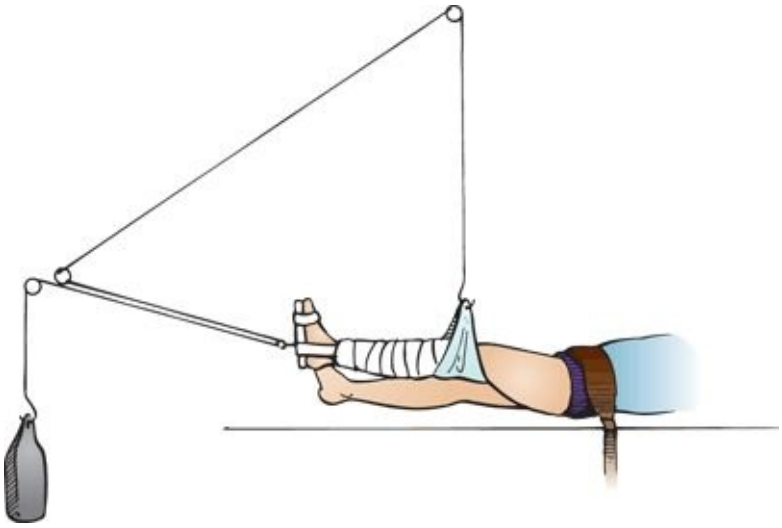
☐ **1.** Elevate the head of the bed.
☐ **2.** Cover the client with a blanket.
☐ **3.** Pull the side rails up.
☐ **4.** Dim the lights in the room.

106. A client with emphysema has been admitted to the hospital. The nurse should assess the client further for:

☐ **1.** Frequent coughing.
☐ **2.** Bronchospasms.
☐ **3.** Underweight appearance.
☐ **4.** Copious sputum.

107. A 12-year-old has a fractured femur and is immobilized in traction as shown in the figure. The nurse should:

☐ **1.** Add additional weight until the foot is only 2 inches (5.1 cm) from the bed.
☐ **2.** Offer foods that are easy to eat.
☐ **3.** Place a pillow under the fractured leg to provide support.
☐ **4.** Provide opportunities for age-appropriate activities.



108. The nurse is participating in a blood pressure screening event. After three separate readings taken at least 2 minutes apart, the nurse determines that a client has a blood pressure of 160/90 mm Hg. The nurse should advise the client to:

☐ **1.** Have blood pressure evaluated within 1 month.
☐ **2.** Begin an exercise program.
☐ **3.** Examine lifestyle to decrease stress.
☐ **4.** Schedule a complete physical immediately.

109. Which of the following activities is **least** effective in preventing sensory deprivation during a client's stay in the cardiac care unit?

☐ **1.** Watching television.
☐ **2.** Visiting with family.
☐ **3.** Reading the newspaper.
☐ **4.** Keeping the door closed to provide privacy.

110. The nurse is teaching a client who is taking dexamethasone (Decadron) for cerebral edema about early symptoms of Cushing's disease. The nurse should advise the client to report which of the following is a symptom of hyperadrenocorticism?

☐ **1.** Hypotension.
☐ **2.** Increased urinary frequency.
☐ **3.** Increased muscle mass.
☐ **4.** Easy bruising.

111. A client's wife arrives on the nursing unit 6 hours after her husband's car accident, explaining that she has been out of town. She is distraught because

she was not with her husband when he was admitted. The nurse should **first**:

☐ **1.** Allow her to verbalize her feelings and concerns.
☐ **2.** Describe her husband's medical treatment since admission.
☐ **3.** Explain the nature of the injury and reassure her that her husband's condition is stable.
☐ **4.** Reassure her that the important fact is that she is here now.

112. A client is scheduled to have a graded exercise test. The nurse explains to the client that the test will determine how:

☐ **1.** Well he thinks under pressure.
☐ **2.** Well his body reacts to controlled exercise stress.
☐ **3.** Far he can walk.
☐ **4.** Long he can walk.

113. A client who has asthma is taking albuterol to treat bronchospasms. The nurse should assess the client for which of the following adverse effects that can occur as a result of taking this drug? Select all that apply.

☐ **1.** Lethargy.
☐ **2.** Nausea.
☐ **3.** Headache.
☐ **4.** Nervousness.
☐ **5.** Constipation.

114. A client fears chemotherapy because of the side effects. What is the nurse's **best** response to the client's concerns?

☐ **1.** “Your health has been excellent. It's unlikely that you'll experience serious side effects.”
☐ **2.** “We'll give you medications to prevent the side effects, so you shouldn't be too concerned.”
☐ **3.** “Each person responds differently to chemotherapy treatments. We'll monitor your responses closely.”
☐ **4.** “It's important for you to accept this treatment. If you refuse your chemotherapy treatments, you'll die.”

115. The mother of an infant with hemophilia tells the nurse that she is planning to do home schooling when the child reaches school age. She does not want her child in school because the teacher will not watch the child as well as she would. The mother's comments represent what common parental reaction to a child's chronic illness?

☐ **1.** Overprotection.
☐ **2.** Devotion.
☐ **3.** Mistrust.

☐ **4.** Insecurity.

116. A mother tells a nurse that her child has been exposed to roseola. After teaching the mother about the illness, which of the following, if stated by the mother as the **most** characteristic sign of roseola, indicates successful teaching?

☐ **1.** Fever and sore throat.
☐ **2.** Normal temperature followed by a low-grade fever.
☐ **3.** High fever followed by a drop and then a rash.
☐ **4.** Coldlike signs and symptoms and a rash.

117. A client with acute psychosis has been taking haloperidol (Haldol) for 3 days. When evaluating the client's response to the medication, which of the following comments reflects the **greatest** improvement?

☐ **1.** “I know these voices aren't really real, but I'm still scared of them.”
☐ **2.** “I'm feeling so restless, and I can't sit still.”
☐ **3.** “Boy, do I need a shower. I think it has been days since I've had one.”
☐ **4.** “I'll be fine if you just let me out of here today.”

118. A 58-year-old homeless person is brought to the emergency department by the police after being found unconscious on the street. Following examination and evaluation of laboratory test results, a diagnosis of diabetic ketoacidosis is confirmed. Which of the following information is **most** crucial to document on the client's chart? Select all that apply.

☐ **1.** Size of pupils and reaction of pupils to light.
☐ **2.** Response to verbal and painful stimuli.
☐ **3.** Skin condition and presence of any rashes, lesions, or ulcers.
☐ **4.** Blood pressure.
☐ **5.** Length of time the client has had diabetes.
☐ **6.** Hourly urine output.

119. An older adult who experienced a brief period of delirium realizes that the condition was caused by prescription medication intoxication. Which of the following statements indicates the need for further education?

☐ **1.** “I never realized that taking a little extra medication now and then could cause such a problem.”
☐ **2.** “I get medicines from three different doctors, and they don't all know what I'm taking.”
☐ **3.** “I thought that the herbal medicines would help me. I never realized they would make me sick.”
☐ **4.** “I didn't know that cold and flu medicines might not mix with my regular medicines.”

120. During an emergency, a physician has asked for IV calcium to treat a

client with hypocalcemia. The nurse should:

☐ **1.** Hand the physician calcium chloride for IV use.
☐ **2.** Check with the physician for the complete prescription.
☐ **3.** Hand the physician calcium gluconate for IV use.
☐ **4.** Hand the physician the kind of calcium available on the unit.

121. The nurse is administering an IV potassium chloride supplement to a client who has heart failure. When developing a plan of care for this client, which of the following should the nurse incorporate?

☐ **1.** Hyperkalemia will intensify the action of the client's digoxin (Lanoxin) preparation.
☐ **2.** The client's potassium levels will be unaffected by a potassium-sparing diuretic.
☐ **3.** The administration of the IV potassium chloride should not exceed 10 or a concentration of 40.
☐ **4.** Metabolic alkalosis will increase the client's serum potassium levels.

122. A client is receiving morphine sulfate by a patient-controlled analgesia (PCA) system after a left lower lobectomy 4 hours ago. The client reports moderately severe pain in the left thorax that worsens when coughing. The nurse's **first** course of action is to:

☐ **1.** Reassure the client that the PCA system is working and will relieve pain.
☐ **2.** Encourage the client to rest; no further assessment is needed.
☐ **3.** Assess the pain systematically with the hospital-approved pain scale.
☐ **4.** Encourage the client to ignore the pain and sleep because pain is expected after this type of surgery.

123. Which of the following factors can most alter tissue tolerance and lead to the development of a pressure ulcer?

☐ **1.** The client's age.
☐ **2.** Exposure to moisture.
☐ **3.** Presence of hypertension.
☐ **4.** Smoking.

124. The nurse is screening clients for cancer prevention. Which of the following is the recommended screening protocol for colon cancer in asymptomatic clients who have a low-risk profile?

☐ **1.** Fecal occult blood testing should be performed annually after age 50 years and up to age 75.
☐ **2.** Digital rectal examinations are recommended every 5 years after age 40 years.
☐ **3.** Sigmoidoscopy is recommended if symptoms of colon problems are

present.

☐ **4.** A low-fat diet should be implemented after age 50 years.

125. The nurse is evaluating the effectiveness of antipsychotic medications in a client with severe Alzheimer's disease. Which of the following changes indicates improvement resulting from medications?

☐ **1.** Adjustment to the structured daily routine.
☐ **2.** Return of the client's short-term memory.
☐ **3.** Decrease in verbal and physical aggression.
☐ **4.** Diminished resistance with activities of daily living done one step at a time.

126. After vaginal birth of a term neonate, the nurse determines that the placenta is about to separate when which of the following occurs?

☐ **1.** The uterus becomes oval shaped.
☐ **2.** The uterus enlarges.
☐ **3.** A sudden gush of dark blood occurs.
☐ **4.** The client expends efforts pushing.

127. The nurse should complete which of the following assessments on a client who has received tissue plasminogen activator or alteplase recombinant (Activase) therapy?

☐ **1.** Neurologic signs frequently throughout the course of therapy.
☐ **2.** Excessive bleeding every hour for the first 8 hours.
☐ **3.** Blood glucose level.
☐ **4.** Arterial blood gas values.

128. During the emergent stage of burn management for a client with burns of 30% of the body, the nurse should assess the client for which of the following? Select all that apply.

☐ **1.** Hyponatremia.
☐ **2.** Hyperkalemia.
☐ **3.** Hypoglycemia.
☐ **4.** Increased hematocrit.
☐ **5.** “Fever spikes.”

129. A 6-year-old child is to have a cardiac catheterization and asks the nurse if it will hurt. Which of the following statements provides the nurse with the **best** guide for responding to the child's question?

☐ **1.** “The medication used to numb the insertion site will sting.”
☐ **2.** “A momentary sharp pain usually occurs when the catheter enters the heart.”
☐ **3.** “Most 6-year-olds feel some discomfort during the procedure.”