

10. A 20-year-old single parent brings her 3-year-old son into the emergency department because he “fell.” The child has bruises on his face, arms, and legs; his mother says that she did not witness the fall. The nurse suspects child abuse. While examining the child, the mother says, “Sometimes I guess I’m pretty rough with him. I’m alone, and I just don’t know how to manage him.” The nurse should ask the mother if she would find it helpful to have a referral to:

- 1. A program for single parents.
- 2. A parenting education program.
- 3. A women’s support group.
- 4. A support group for abusive parents.

11. The nurse is planning to complete the following assessments during the last half hour of the shift. Which of the following assessments has the **highest** priority and should be accomplished first?

- 1. A postpartum couplet with the infant who has had transient tachypnea of the newborn (TTN) at birth and now has a respiratory rate of 60 breaths/minute.
- 2. A newly admitted postpartum client who is receiving magnesium sulfate at 3 g an hour initiated 10 hours ago for preeclampsia; her infant ate poorly previously and has not eaten for 4 hours.
- 3. A mother who had a cesarean section and is 6 hours post delivery with the baby in special care nursery; the mother has not yet seen her baby.
- 4. A couplet that delivered at 36 weeks’ gestation; the 5 lb infant had initial blood glucose of 35 mg/dL and when taken to the room had a glucose of 46 mg/dL.

12. A nurse who fails to check a client’s armband before administering his medications is:

- 1. Res judicata.
- 2. Negligent.
- 3. Stare decisis.
- 4. Vicariously liable.

13. Before administering morphine to a client, the nurse should assess the client’s:

- 1. Blood pressure.
- 2. Respiration rate.
- 3. Pulse.
- 4. Temperature.

14. A client is to receive 1 unit of packed red blood cells over 2 hours. The I.V. administration infusion set delivers 10 gtt/mL. At what flow rate (in drops per minute) should the nurse run the infusion?

_____ gtt/minute.

15. A mother states that she is very angry with the physician who diagnosed her child with leukemia. Which statement helps the nurse understand this mother’s reaction?

- 1. Anger is a natural result of a sense of loss and helplessness.
- 2. Parents of sick children are usually unable to control their anger.
- 3. Anger is rarely demonstrated by parents when coping with a sick child.
- 4. The mother cannot overcome her anger in an acceptable manner.

16. Which of the following nursing strategies would be effective in managing a resident in a long-term care facility who has Alzheimer’s disease and wanders?

- 1. Encourage participation in activities such as board games.
- 2. Discourage wandering by allowing the behavior at selected intervals.
- 3. Involve the client in activities that promote walking.
- 4. Promote safety by restraining the client in a geriatric chair.

17. A child who had a cast applied to his arm earlier this morning tells the nurse that his fingers are numb. The nurse should:

- 1. Notify the physician who applied the cast.
- 2. Cut the cast to loosen it.
- 3. Assess the circulation to the fingers.
- 4. Ensure that the arm is positioned correctly.

18. A client is admitted with low back pain (LBP). The nurse should further assess the client for:

- 1. Osteoporosis.
- 2. Herniated disk.
- 3. Muscle strain.
- 4. Spondylosis.

19. While helping clients brought to a crisis center during a severe flood, the nurse interviews a client whose pregnant wife is missing and whose home has been destroyed. The client keeps talking rapidly about his experience and says, “I can’t see how I can ever rebuild my life.” Which of the following responses by the nurse would be **most** appropriate?

- 1. “If you start organizing your life now, I’m sure all will be fine.”
- 2. “This has been a terrible experience. Tell me more about how you feel.”
- 3. “Let me note a few of the things you said before you continue with your story.”
- 4. “Tonight, think some more of what happened, so that we can continue with this tomorrow.”

20. A client with asthma has been prescribed beclomethasone (Beclvent) via metered-dose inhaler. To determine if the client has been rinsing the mouth after each use of the inhaler, the nurse should inspect the client's mouth for:

- 1. Gingival hyperplasia.
- 2. Oral candidiasis.
- 3. Ulceration
- 4. Dental caries.

21. The nurse finds a client lying on the floor next to the bed. After returning the client to bed, assessing for injury, and notifying the physician, the nurse fills out an incident report. Which of the following is the nurse's **next** action?

- 1. Give the incident report to the nurse-manager.
- 2. Place the incident report on the chart.
- 3. Call the family to inform them.
- 4. Omit mentioning the fall in the chart documentation.

22. The charge nurse on an antepartal unit is preparing to complete assignments for the day. There is an RN, licensed practical nurse (LPN), and an unlicensed personnel (UAP) to care for 25 clients. The nurse should assign which of the following clients to the LPN?

- 1. A newly admitted G5 P2 Ab 2 with second trimester bleeding, reportedly currently saturating 1-2 pads in 12 hours.
- 2. A 22-year-old G2 P1 with urinary retention who is being catheterized with an intermittent in and out every 4 to 6 hours p.r.n. while awaiting urine cultures to be returned.
- 3. A G4 P2 with a twin pregnancy who was admitted in preterm labor and is now able to ambulate 2 to 3 times daily and having no contractions.
- 4. A 30-year-old G4 P0 who was admitted in sickle cell crisis currently receiving blood and pain medication.

23. The mother of 2-year-old who has been bitten by the family dog asks the nurse what to do about the bite. What should the nurse tell the mother?

- 1. "You need to take the child to the local urgent care center immediately."
- 2. "Wash the bite area with lots of running water, and then check the injury."
- 3. "Determine when the child's latest tetanus vaccine was administered."
- 4. "Make an appointment to see the child's physician now to start rabies shots."

24. 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."

25. A schoolteacher asks the nurse whether all the children at school need treatment after exposure to a 7-year-old child with bacterial meningitis. The nurse responds that chemoprophylaxis should be given to:

- 1. All children at the school.
- 2. All household contacts and close contacts.
- 3. The entire community.
- 4. Household contacts only.

26. The mother of a newborn is concerned about the number of persons with heart disease in her family. She asks the nurse when she should start her baby on a low fat, low cholesterol diet to lower the risk of heart disease. The nurse should tell her to start diet modifications:

- 1. At birth.
- 2. At age 2.
- 3. At age 5.
- 4. At age 10.

27. A client is being treated for severe pediculosis. The nurse should instruct the client to treat the problem in the eyebrows and eyelashes by:

- 1. Applying petroleum jelly to lashes and brows three to four times a day.
- 2. Applying a pediculicide with a cotton-tipped swab three to four times a day.
- 3. Applying lindane ointment to the lashes and eyebrows three times a day.
- 4. Applying bacitracin ointment to the lashes and brows three times a day.

28. The nurse is discussing safety and accident prevention with the mother of a 9-month-old. The teaching has been effective when the mother states which of the following?

- 1. "I make sure that I keep my cleaning supplies locked up."
- 2. "Sometimes she plays in the bathroom when I'm cleaning in there."
- 3. "Occasionally she gets under the chair and plays with the telephone cord."
- 4. "I've found that those child-protective cabinet locks don't work very well."

29. When assessing a child receiving tobramycin sulfate (Nebcin), which findings would indicate that the child is experiencing adverse effects? Select all that apply.

- 1. Increased blood pressure.
- 2. Weight gain.
- 3. Rash.
- 4. Fever.
- 5. Ringing in the ears.
- 6. Decreased heart rate.

30. The nurse instructs the client who is taking gentamicin to monitor factors related to renal function. The nurse determines that the client needs additional instruction when he makes which of the following statements?

- 1. "I should call you if I notice that I'm not urinating as much."
- 2. "I should call you if my urine looks dark or unusual."
- 3. "I should call you if my legs swell or I notice my skin looks puffy around my eyes."
- 4. "I should call you if I have a fever."

31. A 15-month-old child is admitted to the pediatric unit with the diagnosis of pneumonia and is placed in a mist tent. Which of the following toys would be appropriate for this child?

- 1. A pull toy.
- 2. Storybooks.
- 3. Crayons and paper.
- 4. Plastic blocks.

32. When teaching a group of parents about the potential for febrile seizures in children, which of the following facts should the nurse include?

- 1. The exact cause is known.
- 2. The seizures occur as the fever rises.
- 3. Children older than age 3 are most at risk.
- 4. These seizures commonly occur after immunization administration.

33. A 19-year-old G1 P0 is being discharged home after hospitalization for hyperemesis gravidarum and is being referred to home health care. The nurse should develop a discharge plan that includes which of the following? Select all that apply.

- 1. Refer client to a nutritionist for the following day.
- 2. Ensure that the client has a prescription for an antiemetic.
- 3. Ask the health care provider (HCP) for an anxiolytic prescription.
- 4. Encourage return to normal routine when client feels ready.
- 5. Coordinate follow-up appointment with provider in 6 weeks.
- 6. Discuss plan of care and discharge instructions with client.

34. The nurse should instruct a woman taking folic acid supplements for folic acid-deficiency anemia that:

- 1. It will take several months to notice an improvement.
- 2. Folic acid should be taken on an empty stomach.
- 3. Iron supplements are contraindicated with folic acid supplementation.
- 4. Oral contraceptive use, pregnancy, and lactation increase daily requirements.

35. The nurse makes a home visit to a primiparous client and her neonate at 1 week after a vaginal delivery. Which of the following findings should be reported to the physician?

- 1. A scant amount of maternal lochia serosa.
- 2. The presence of a neonatal tonic neck reflex.
- 3. A nonpalpable maternal fundus.
- 4. Neonatal central cyanosis.

36. The nurse is obtaining a health history for a client with osteoporosis. The nurse should specifically ask the client about which of the following? Select all that apply.

- 1. Amount of alcohol consumed daily.
- 2. Use of antacids.
- 3. Dietary intake of fiber.
- 4. Use of Vitamin K supplements
- 5. Intake of fruit juices

37. The nurse tells a rape victim that even if she was protected against pregnancy by a contraceptive and has no intention of taking any legal action against her assailant, she should still be checked by a physician for early detection of which of the following?

- 1. Sexually transmitted disease.
- 2. Anxiety reaction.
- 3. Periurethral tears.
- 4. Menstrual difficulties.

38. A hospitalized client fell on the floor and sustained a small laceration on her hand that required stitches. The intern will suture the client's hand at the client's bedside and asks for bupivacaine (Marcaine) with epinephrine and a suture kit in order to suture the laceration. The nurse should question which of the following?

- 1. The intern's ability to suture.
- 2. The client's room as an aseptic environment.
- 3. Marcaine with epinephrine as the local anesthetic.
- 4. The cosmetic effect from not having a plastic surgeon do the suturing.

39. Which of the following signs and symptoms experienced by a child with suspected appendicitis should the nurse correctly judge to be unrelated to the transient sympathetic effects caused by the acute abdominal pain?

- 1. Tachycardia.
- 2. Chills.
- 3. Rapid breathing.
- 4. Dilated pupils.

40. When assessing a dark-skinned client for cyanosis, the nurse should examine which of the following?

- 1. The client's retinas.
- 2. The client's nail beds.
- 3. The client's oral mucous membranes.
- 4. The inner aspects of the client's wrists.

41. Betamethasone (Celestone) syrup 0.9 mg has been ordered. It is available in a 0.6 mg/5 mL solution. How many milliliters should the nurse administer?

_____ mL.

42. A client at 37 weeks' gestation is scheduled for a biophysical profile. Which of the following should the nurse instruct the client to do **before** the test?

- 1. Drink 1 to 2 L of fluid.
- 2. Take nothing by mouth after midnight before the test.
- 3. Plan to remain in the clinic for 4 hours after the test.
- 4. Eat a high-fiber meal after the test.

43. A 12-year-old boy is admitted due to depression and post-trauma response. Child Protective Services reports that the boy's father is now in jail for molesting him from ages 6 to 9. Given the typical reactions of incest victims, the nurse should assess the child for which behavior? Select all that apply.

- 1. Sexualized play.
- 2. Aggression.
- 3. Isolation at home.
- 4. Running away.
- 5. Truancy.

44. Which of the following is true with regard to delegation of client care responsibilities? Select all that apply.

- 1. The nurse must know the nursing model that underlies care at the institution.
- 2. The nurse delegates in accordance with demands on his/her time.
- 3. The nurse validates with the non-RN caregiver that he/she has performed the same activity before.
- 4. The nurse retains the right to determine which tasks are delegated.
- 5. The nurse must document that the task has been delegated and to whom.

45. A mother is concerned about the amount of snacking her teenage boy is doing. She is concerned that this behavior could lead to obesity. Which of the following is an appropriate percentage of the daily diet to be obtained from snacks?

- 1. 10%.
- 2. 25%.
- 3. 40%.
- 4. 50%.

46. The client has sore nares while a nasogastric (NG) tube is in place. Which of the following nursing measures would be **most** appropriate to help alleviate the client's discomfort?

- 1. Reposition the tube in the nares.
- 2. Irrigate the tube with a cool solution.
- 3. Apply a water-soluble lubricant to the nares.
- 4. Have the client change position more frequently.

47. The nurse is instructing a Hindu client to increase protein in the diet. Which of the following foods are appropriate to include in this client's diet? Select all that apply.

- 1. Lentil soup
- 2. Hamburger.
- 3. Steak.
- 4. Veal cutlet.
- 5. Broiled fish sandwich.

48. A child with partial- and full-thickness burns is admitted to the pediatric unit. Which of the following should be the **priority** at this time?

- 1. Preventing wound infection.
- 2. Evaluating vital signs frequently.
- 3. Maintaining fluid and electrolyte balance.
- 4. Managing the child's pain.

49. A normal, healthy infant is brought to the clinic for the first immunization against polio. The nurse should administer this vaccine by what route?

- 1. Oral route.
- 2. I.M. route.
- 3. Subcutaneous route.
- 4. Intradermal route.

50. A child has been prescribed diphenhydramine hydrochloride (Benadryl) to help control the itching from atopic dermatitis. The nurse should instruct the parents to report: Select all that apply.

- 1. Weight loss.
- 2. Drowsiness.
- 3. Thickened bronchial secretions.
- 4. Upset stomach.
- 5. Bradycardia.

51. The nurse observes that a client who has received midazolam (Versed) for local anesthesia is having shallow respirations. The nurse should:

- 1. Encourage the client to deep-breathe.
- 2. Have respiratory resuscitation equipment in the room.
- 3. Administer oxygen as ordered.
- 4. Administer naloxone (Narcan).

52. The nurse is planning to assist the physician with a thoracentesis for a client who has a pleural effusion. Which of the following positions would be appropriate for the client to assume?

- 1. Lying supine with the arms extended.
- 2. Lying prone with the head supported by the arms.
- 3. Sitting upright and leaning on an overbed table.
- 4. Side-lying with the knees drawn up to the abdomen.

53. The nurse is preparing a presentation on nutrition to a group of pregnant adolescents. Which of the following would be important for the nurse to include in the teaching plan?

- 1. Spinach is an excellent source of calcium in the diet.
- 2. Two to four servings of whole-grain products is recommended.
- 3. Three or more servings of dairy products meet the calcium requirement.
- 4. Vitamin A supplements may be necessary for clients who are vegetarian.

54. A client has a viral (coxsackie B) or trypanosomal (parasite) infection. The nurse should further assess the client for:

- 1. Myocarditis.
- 2. Myocardial infarction.
- 3. Renal failure.
- 4. Liver failure.

55. Which of the following would be true regarding medication reconciliation? Select all that apply.

- 1. Medication reconciliation is a Joint Commission National Patient Safety Goal.
- 2. Medication reconciliation is designed to obtain and communicate an accurate list of a client's home medications across the continuum of care.
- 3. Only nurses or health care providers can be involved in medication reconciliation.
- 4. Medications are considered reconciled if a medication order exists that is therapeutically equivalent to the one prior to admission.
- 5. A medication is considered to be any medication ordered by a physician.

56. Which of the following compensatory actions by the body would occur if a client were in respiratory acidosis?

- 1. Excretion of bicarbonate (HCO_3^-) by the kidneys.
- 2. Retention of HCO_3^- by the kidneys.
- 3. Increase in respiratory rate by the lungs.
- 4. Decrease in respiratory rate by the lungs.

57. A client has started taking amiodarone (Cordarone). The nurse should inform the client that periodic laboratory tests will be done to monitor the client's:

- 1. Hemoglobin.
- 2. Liver enzymes.
- 3. Creatine kinase (CK) concentration.
- 4. Renal function.

58. A 9-month-old child has been diagnosed with an ear infection. The father asks what else to do to help his child. The nurse can tell the father:

- 1. "Your child should also take an antihistamine."
- 2. "The antibiotic is the only medicine necessary."
- 3. "Cotton in the ears helps the discomfort."
- 4. "Over-the-counter eardrops often are helpful."

59. A child's plan of care lists increasing protein intake as a goal. Which of the following foods that the child likes should the nurse encourage the child to eat?

- 1. A bacon, lettuce, and tomato sandwich.
- 2. Fruit-flavored yogurt.
- 3. Nacho chips and salsa.
- 4. Crackers with butter and jelly.

60. Thirty minutes after a Sengstaken-Blakemore tube is inserted, the nurse observes that the client appears to be having difficulty breathing. The nurse's **first** action should be to:

- 1. Remove the tube.
- 2. Deflate the esophageal portion of the tube.
- 3. Determine whether the tube is obstructing the airway.
- 4. Increase the oxygen flow rate.

61. A client is taking ciprofloxacin (Cipro). Which of the following laboratory studies will not be affected by ciprofloxacin?

- 1. Theophylline level.
- 2. Prothrombin time (PT).
- 3. Partial thromboplastin time (PTT).
- 4. Total iron-binding capacity.

62. A 10-year-old child is diagnosed with pediculosis. The mother is concerned about the spread of the lice to children who have been in contact with her child. The nurse should instruct the mother to have her child avoid:

- 1. Sharing craft supplies.
- 2. Having contact during a swimming class.
- 3. Sharing batting helmets.
- 4. Showering after football practice.

63. A 24-year-old nulligravid client with a history of irregular menstrual cycles visits the clinic because she suspects that she is “about 6 weeks pregnant.” An ultrasound is scheduled in 2 weeks. The nurse should instruct the client that this test will be done to:

- 1. Assess gestational age.
- 2. Determine a multifetal pregnancy.
- 3. Identify the gender of the fetus.
- 4. Assess of maternal pelvic adequacy.

64. A client with a history of peptic ulcer disease is admitted to the hospital. Initial assessment reveals that his blood pressure is 96/60 mm Hg, his pulse rate is 120 bpm, and he has vomited coffee-ground material. Based on this assessment, what is the nurse’s **priority** action?

- 1. Administer an antiemetic.
- 2. Prepare to insert a nasogastric (NG) tube.
- 3. Collect data regarding recent client stressors.
- 4. Place the client in a modified Trendelenburg position.

65. In the early postoperative period, the nurse notes a bright red, 3” × 5” area of drainage on the client’s abdominal laparotomy dressing. What should be the nurse’s **first** action in response to this observation?

- 1. Ignore it because drainage is normal.
- 2. Increase the I.V. flow rate.
- 3. Take the client’s vital signs.
- 4. Change the dressing.

66. A 6-year-old client is diagnosed with attention deficit hyperactivity disorder (ADHD). When asking this client to complete a task, what techniques should the nurse use to communicate **most** effectively with him?

- 1. Obtain eye contact before speaking, use simple language, and have him repeat what was said. Praise him if he completes the task.
- 2. Fully explain to the client the actions required of him, offer verbal praise and a food reward for task completion.
- 3. Explain to the client what he is to do, the consequences if he does not comply, and follow through with praise or consequences as appropriate.
- 4. Demonstrate to the client what he is to do, have him imitate the nurse’s actions, and give a food reward if he completes the task.

67. A 10-year-old child has the following blood glucose readings during a 24-hour period. Which reading requires the **most** immediate intervention?

- 1. 50 mg/dL.
- 2. 100 mg/dL.
- 3. 150 mg/dL.
- 4. 200 mg/dL.

68. A client has massive bleeding from esophageal varices. In what order should the nurse and care team provide care for this client?

1. Control hemorrhaging.

2. Replace fluids.

3. Relieve the client’s anxiety.

4. Maintain a patent airway.

69. Which of the following would be **most** important for the nurse to include in the teaching plan for a client who is taking phenelzine (Nardil)?

- 1. Eating a normal amount of salt in the diet.
- 2. Drinking 10 to 12 glasses of water each day.
- 3. Allowing 10 days to achieve therapeutic effects.
- 4. Avoiding foods high in tyramine.

70. The nurse should closely monitor the client with an open fracture for which of the following complications?

- 1. Avascular necrosis.
- 2. Compartment syndrome.
- 3. Osteomyelitis.
- 4. Fat embolism syndrome.

71. Which of the following should be a priority nursing diagnosis for a client who has had a total laryngectomy?

- 1. *Risk for impaired skin integrity.*
- 2. *Excess fluid volume.*
- 3. *Ineffective thermoregulation.*
- 4. *Impaired verbal communication.*

72. The nurse is assessing a client who has a long history of uncontrolled hypertension. The nurse should assess the client for damage in which area of the eye?

- 1. Iris.
- 2. Cornea.
- 3. Retina.
- 4. Sclera.

73. While preparing to provide neonatal care instructions to a primiparous client who delivered a term neonate 24 hours ago, which of the following should the nurse include in the client's teaching plan?

- 1. Term neonates generally have few creases on the soles of their feet.
- 2. Strawberry hemangiomas—deep, dark red discolorations—require laser therapy for removal.
- 3. Milia are white papules from plugged sebaceous ducts that disappear by age 2 to 4 weeks.
- 4. If erythema toxicum is present, it will be treated with antibiotic therapy.

74. Two days after being placed in a cast for a fractured femur, the client suddenly complains of chest pain and dyspnea. The client is confused and has an elevated temperature. The nurse should assess the client for:

- 1. Osteomyelitis.
- 2. Compartment syndrome.
- 3. Venous thrombosis.
- 4. Fat embolism syndrome.

75. A client has received an overdose of sympathomimetic agents. The nurse should assess the client for which of the following **late** signs of an overdose? Select all that apply.

- 1. Hypotension.
- 2. Bradycardia.
- 3. Seizures.
- 4. Profound pyrexia.
- 5. Hypertension.

76. While assessing a neonate at 4 hours after birth, the nurse observes an indentation with a small tuft of hair at the base of the neonate's spine. The nurse should document this finding as which of the following?

- 1. Spina bifida cystica.
- 2. Spina bifida occulta.
- 3. Meningocele.
- 4. Myelomeningocele.

77. A nurse is administering indomethacin to a neonate. To ensure that the nurse has identified the neonate correctly, the nurse should do which of the following? Select all that apply.

- 1. Ask the parents to confirm that this is their baby.
- 2. Ask another nurse to confirm that this is the neonate for whom the medication has been prescribed.
- 3. Check the neonate's identification band against the medical record number.
- 4. Verify the date of birth from the medical record with the date of birth on the client's identification band.
- 5. Compare the number on the crib with the number on the client's identification band.

78. The nurse instills 5 mL of normal saline before suctioning a client's tracheostomy tube. The instillation is effective when:

- 1. The secretions are thinned.
- 2. The client coughs.
- 3. There is minimal friction when the catheter is passed into the tracheostomy tube.
- 4. There is humidification for the respiratory tract.

79. A client with emphysema is receiving continuous oxygen therapy. Depressed ventilation is likely to occur unless the nurse ensures that the oxygen is administered in which of the following ways?

- 1. Cooled.
- 2. Humidified.
- 3. At a low flow rate.
- 4. Through nasal cannula.

80. A client at 12 weeks' gestation tells the nurse that she is a vegetarian and eats "lots of rice." To help meet the client's need for protein during pregnancy, the nurse suggests that the client combine the rice with which of the following?

- 1. Beans.
- 2. Soy milk.
- 3. Yogurt.
- 4. Corn.

81. A client with rheumatoid arthritis tells the nurse that she feels "quite alone" in adjusting to changes in her lifestyle. Which of the following nursing actions is **most** appropriate in response to this statement?

- 1. Refer the client and her husband for counseling to decrease her sense of isolation.
- 2. Suggest that the client develop a hobby to occupy her time.
- 3. Tell the client about her community's arthritis support group.
- 4. Suggest that the client discuss her feelings with her minister.

82. Which of the following should the nurse expect to include in the plan of care to ensure adequate nutrition for a very active, talkative, and easily distractible client who is unable to sit through meals?

- 1. Direct the client to his room to eat.
- 2. Offer the client nutritious finger foods.
- 3. Ask the client's family to bring his favorite foods from home.
- 4. Ask the client about his food preferences.

83. A client is very dependent on the staff but is able to make simple decisions. The client asks, "Would you do my laundry? I don't know how the machine works." Which of the following responses would be **best**?

- 1. "Sure, I have time; I can do it for you."
- 2. "You'll have to wait; I don't have time now."
- 3. "Can your family do it for you?"
- 4. "Get your laundry; I'll show you how the machine works."

84. The nurse is caring for a client with chronic renal failure. Knowing that the client is a candidate for development of hypermagnesemia, for which of the following signs and symptoms should the nurse closely monitor the client?

- 1. Flushed skin.
- 2. Lethargy.
- 3. Severe thirst.
- 4. Tremors.

85. When determining the parents' compliance with treatment for their infant who has otitis media, the nurse should ask the parents if they are:

- 1. Cleaning the child's ear canals with hydrogen peroxide.
- 2. Administering continuous, low-dose antibiotic therapy.
- 3. Instilling ear drops regularly to prevent cerumen accumulation.
- 4. Holding the child upright when feeding with a bottle.

86. When giving a change of shift report, which of the following statements by the nurse is **not** appropriate?

- 1. "Randi Smith is a 38-year-old female client of Dr. Born with cholecystitis and cholelithiasis."
- 2. "Mrs. Jones' pain is best relieved in the left lateral Sims position."
- 3. "Mr. Levi is just contrary today and nothing is going to please him."
- 4. "Mr. Emmert was able to walk around the unit twice today with no complaint of dizziness."

87. The nurse is teaching unlicensed assistive personnel about caring for a client who is withdrawing from alcohol and street drugs. Which of the following communication techniques when observed by the nurse indicate the UAP has understood the instructions?. The UAP talks to the client using:

- 1. Matter-of-fact manner and short sentences.
- 2. Cheerful tone of voice, using humor when appropriate.
- 3. Loud voice and giving general comments.
- 4. Clear explanations in a quiet voice.

88. A couple has completed testing and is a candidate for in vitro fertilization. The nurse is reviewing the procedure with them and realizes that further instruction is needed when the woman states:

- 1. "One of the greatest risks is multiple pregnancies."
- 2. "I will need to redefine how I view my job if I do become pregnant."
- 3. "The fertilization procedure can be done anytime during my cycle."
- 4. "We can use our own eggs and sperm or someone else's."

89. When obtaining the diet history from a client with anemia, the nurse should include questions specifically about which of the following vitamins or minerals that are most likely missing in this client's diet? Select all that apply.

- 1. Vitamin B₆.
- 2. Vitamin K.
- 3. Vitamin B₁₂.
- 4. Iron.
- 5. Vitamin C.

90. What is the **primary** goal of nursing care during the emergent phase after a burn injury?

- 1. Replace lost fluids.
- 2. Prevent infection.
- 3. Control pain.
- 4. Promote wound healing.

91. The nurse assesses for euphoria in a client with multiple sclerosis, looking for which of the following characteristic clinical manifestations?

- 1. Inappropriate laughter.
- 2. An exaggerated sense of well-being.
- 3. Slurring of words when excited.
- 4. Visual hallucinations.

92. The client with a burn injury is assessed using the "rule of nines" to determine which of the following?

- 1. Amount of body surface area burned.
- 2. Rehabilitation needs.
- 3. Respiratory needs.
- 4. Type of intravenous fluids required.

93. When assessing a 2-month-old infant, the nurse feels a “click” when abducting the infant’s left hip. Which of the following should the nurse do **next**?

- 1. Document the finding as normal for a 2-month-old.
- 2. Check the lengths of the femurs to determine if they are equal.
- 3. Instruct the mother to keep the leg in an adducted position.
- 4. Reschedule the child for a follow-up assessment in 3 weeks.

94. Which of the following laboratory tests should the nurse monitor when the client is receiving warfarin sodium (Coumadin) therapy?

- 1. Partial thromboplastin time (PTT).
- 2. Serum potassium.
- 3. Arterial blood gas (ABG) values.
- 4. Prothrombin time (PT).

95. A client who had transurethral resection of the prostate (TURP) 2 days earlier is complaining of lower abdominal pain. The nurse should:

- 1. Auscultate the abdomen for bowel sounds.
- 2. Administer an oral analgesic.
- 3. Have the client use a sitz bath for 15 minutes.
- 4. Assess the patency of the urethral catheter.

96. The nurse is ready to administer a partial fill of imipenem-cilastatin (Primaxin) in the I.V. pump when a full partial fill bag of imipenem-cilastatin is found hanging at the client’s bedside. Which of the following is not an appropriate response for the nurse when recognizing that the previous dose was not administered 8 hours ago to the client with pneumonia?

- 1. Discard the full partial fill of imipenem-cilastatin found hanging at the client’s bedside.
- 2. Check the identifying information of the full partial fill of imipenem-cilastatin found hanging at the client’s bedside.
- 3. Follow up on the legal documentation of the client’s previous administration of imipenem-cilastatin.
- 4. Administer the new partial fill of imipenem-cilastatin.

97. A client with a moderate level of anxiety is pacing quickly in the hall. As the nurse approaches, he states, “Help me. I can’t take it anymore.” Which of the following would be the **best** response initially?

- 1. “It would be best if you would lie down until you’re calmer.”
- 2. “Let’s go to a quieter area where we can talk if you want.”
- 3. “Try doing your relaxation exercises to calm down.”
- 4. “I’ll get some medicine to help you relax.”

98. The nurse should plan to teach a client who is taking warfarin sodium (Coumadin) to do which of the following?

- 1. Consult the physician before undergoing dental work.
- 2. Avoid the use of a toothbrush during oral hygiene.
- 3. Use rectal suppositories to treat constipation.
- 4. Eat green leafy vegetables.

99. A 30-year-old client is hospitalized with a fractured femur, which is being treated with skeletal traction. He states that he has not had a bowel movement for 2 days. Which of the following interventions is **most** appropriate at this time?

- 1. Administer a tap water enema.
- 2. Place the client on the bedpan every 2 to 3 hours.
- 3. Increase the client’s fluid intake to 3,000 mL/day.
- 4. Perform range-of-motion movements to all extremities.

100. A client is receiving a tube feeding and has developed diarrhea, cramps, and abdominal distention. Which of the following interventions would be **most** appropriate? Select all that apply.

- 1. Change the feeding apparatus every 24 hours.
- 2. Use a higher volume of formula because the formula may be too hypotonic.
- 3. Slow the administration rate.
- 4. Use a diluted formula, gradually increasing the volume and concentration.
- 5. Anticipate changing to a lactose-free formula.

101. A 62-year-old client with a 29-pack per year history is admitted with a diagnosis of lung cancer. She reports having “no appetite” and exhibits symptoms of anorexia. The client is 5 feet, 8 inches tall and weighs 112 lb. The client is now scheduled for a left lung lobectomy. Which of the following increases the client’s risk of developing postoperative pulmonary complications?

- 1. The client tends to keep her real feelings to herself.
- 2. The client ambulates and can climb one flight of stairs without dyspnea.
- 3. The client is age 62.
- 4. The client is 5 feet, 8 inches tall and weighs 112 lb.

102. When developing the plan of care for a 12-year-old child who is to receive 48 hours of chemotherapy that is associated with nausea and vomiting, at which of the following times should the nurse anticipate administering an antiemetic?

- 1. 30 minutes after the chemotherapy has started, then every 4 to 6 hours.
- 2. 30 minutes before the chemotherapy starts, then every 4 to 6 hours.
- 3. When the 12-year-old requests medication for nausea, then every 4 hours as needed.
- 4. On starting the chemotherapy infusion, and then routinely every 8 hours.

103. The membranes of a multigravid client in active labor rupture spontaneously, revealing greenish colored amniotic fluid. The nurse interprets this finding as related to which of the following?

- 1. Passage of meconium by the fetus.
- 2. Maternal intrauterine infection.
- 3. Rh incompatibility between mother and fetus.
- 4. Maternal sexually transmitted disease.

104. A client's arterial blood gas values are as follows:

Laboratory Results	
Test	Result
pH	7.24
Paco ₂	35 mm Hg
HCO ₃ ⁻	15 mEq/L

These findings indicate which of the following acid-base imbalances?

- 1. Metabolic acidosis.
- 2. Metabolic alkalosis.
- 3. Respiratory acidosis.
- 4. Respiratory alkalosis.

105. A client is suspected of having a slow gastrointestinal bleed. The nurse should evaluate the client for which sign or symptom?

- 1. Increased pulse.
- 2. Nausea.
- 3. Tarry stools.
- 4. Abdominal cramps.

106. Which of the following suggestions should the nurse give to an adolescent football player with Osgood-Schlatter disease of the left knee?

- 1. Apply ice on the knee after playing.
- 2. Use crutches until healing has occurred.
- 3. Stop playing until healing has occurred.
- 4. Make an appointment with a physical therapist.

107. The nurse instructs a client who is taking iron supplements that:

- 1. Iron supplements should be taken on an empty stomach.
- 2. A daily bulk laxative such as psyllium hydrophilic mucilloid (Metamucil) should be avoided.
- 3. The stools will become darker.
- 4. Liquid iron supplements will not discolor teeth.

108. Which of the following should the nurse teach a client with generalized anxiety disorder to help the client cope with anxiety?

- 1. Cognitive and behavioral strategies.
- 2. Issue avoidance and denial of problems.
- 3. Rest and sleep.
- 4. Withdrawal from role expectations and role relationships.

109. After a lobectomy for lung cancer, the nurse instructs the client to perform deep-breathing exercises to:

- 1. Decrease blood flow to the lungs for rest and increased surface alveoli ventilation.
- 2. Elevate the diaphragm to enlarge the thorax so that the lung surface area available for gas exchange is increased.
- 3. Control the rate of air flow to the remaining lobe to decrease the risk of hyperinflation.
- 4. Expand the alveoli and increase lung surface available for ventilation.

110. Which of the following would demonstrate the correct technique for applying an elastic bandage to a leg?

- 1. Increase tension with each successive turn of the bandage.
- 2. Start at the distal end of the extremity and move toward the trunk.
- 3. Secure the bandage with clips over the area of the inner thigh.
- 4. Overlap each layer twice when wrapping.

111. A nulliparous client says that she and her husband plan to use a diaphragm with spermicide to prevent conception. Which of the following should the nurse include as the action of spermicides when teaching the client?

- 1. Destruction of spermatozoa before they enter the cervix.
- 2. Prevention of spermatozoa from entering the uterus.
- 3. A change in vaginal pH from acidic to alkaline.
- 4. Slowing of the movement of the migrating spermatozoa.

112. A client with acquired immunodeficiency syndrome (AIDS) is admitted because of paranoia and visual hallucinations probably related to progressive dementia. The client continues to be restless and have hallucinations. The nurse calls the physician, and after explaining the situation, background, and assessment recommends that the physician consider writing an order for the client to have:

- 1. Methylphenidate (Ritalin).
- 2. Lorazepam (Ativan).
- 3. Nefazodone (Serzone).
- 4. Sertraline (Zoloft).

113. Which of the following assessment finding is expected in a client with bacterial pneumonia?

- 1. Increased fremitus.
- 2. Bilateral expiratory wheezing.
- 3. Resonance on percussion.
- 4. Vesicular breath sounds.

114. A client is admitted with severe abdominal pains and the diagnosis of acute pancreatitis. The nurse should develop a plan of care during the acute phase of pancreatitis that will involve interventions targeting which of the following problems?

- 1. Drug and alcohol abuse.
- 2. Risk for injury.
- 3. Severe pain.
- 4. Ineffective airway clearance.

115. A diabetic client who takes insulin is being seen by the nurse for a low blood glucose level. Which of the following would be the **best** choices to begin to raise the blood glucose level? Select all that apply.

- 1. One-half cup of orange juice.
- 2. One cup of milk.
- 3. One ounce of tuna.
- 4. One tablespoon of peanut butter.
- 5. One piece of bread.
- 6. One-half cup of regular soda.

116. An infant with increased intracranial pressure (ICP) on a regular diet vomits while eating dinner. Which of the following should the nurse do **next**?

- 1. Put the child on nothing-by-mouth (NPO) status for 4 hours.
- 2. Call to report this event to the physician.
- 3. Wait a few minutes, then refeed the child.
- 4. Administer the prescribed antiemetic.

117. When preparing to draw up 8 units of a short-acting insulin and 20 units of a long-acting insulin in the same syringe, the nurse should:

- 1. Inject air in the vial with the long-acting insulin first.
- 2. Draw up the long-acting insulin first.
- 3. Draw up either insulin first.
- 4. Use a high-dose insulin syringe.

118. The mother of an infant with iron deficiency anemia asks the nurse what she could have done to prevent the anemia. The nurse should teach the mother that it is helpful to introduce solid foods into the infant's diet at age:

- 1. 1 to 2 months.
- 2. 5 to 6 months.
- 3. 8 to 10 months.
- 4. 10 to 12 months.

119. The nurse is caring for a client who is having an acute asthma attack. The nurse should notify the physician of which of the following?

- 1. Loud wheezing.
- 2. Tenacious, thick sputum.
- 3. Decreased breath sounds.
- 4. Persistent cough.

120. Which of the following skin care instructions would be appropriate for a client receiving radiation therapy?

- 1. Avoid shaving with straight-edge razors.
- 2. Clean the skin daily with antibacterial soap.
- 3. Apply moisturizing lotion before and after each treatment.
- 4. Keep the radiated area covered with a sterile gauze dressing.

121. A client has had a cardiac catheterization. The left femoral dressing has a moderate amount of bloody drainage, and the client has severe pain in that area. The nurse should **first**:

- 1. Assess the airway.
- 2. Administer oxygen.
- 3. Apply pressure to the site.
- 4. Assess the pulse in the left extremity.

122. The nurse should instruct the parent of a child who is taking valproic acid (Depakene) that the child will need to have routine blood analyses consisting of which of the following?

- 1. Complete blood count (CBC) and alkaline phosphate level.
- 2. Cholesterol and platelet levels.
- 3. Electrolytes and CBC.
- 4. Platelet and fibrinogen levels.

123. Bacterial conjunctivitis has affected several children at a local day care center. A nurse should advise which measure to minimize the risk of infection?

- 1. Close the day care center for 1 week to control the outbreak.
- 2. Restrict the infected children from returning for 48 hours after treatment.
- 3. Perform thorough hand washing before and after touching any child in the day care center.
- 4. Set up a conference with the parents of each child to explain the situation carefully.

124. The nurse is evaluating the client's potential for development of a pressure sore. Which of the following individual characteristics would be the **best** indicator of risk for the client's developing a pressure sore?

- 1. The client's nutritional status.
- 2. The client's circulatory status.
- 3. The client's mobility status.
- 4. The client's orientation status.

125. A client with acute pancreatitis is put on nothing-by-mouth status, with the intent of not stimulating the pancreas. The client is prescribed an I.V. infusion of dextrose 5% in half-normal saline solution at 120 mL/hour. After 3 days of this regimen, the nurse should observe the client for which of the following metabolic conditions?

- 1. Ketosis.
- 2. Hyperglycemia.
- 3. Metabolic syndrome.
- 4. Lactic acidosis.

126. While the nurse is assisting a client to ambulate as part of his cardiac rehabilitation program, the client tells the nurse he is having midsternal burning. The nurse should next:

- 1. Stop and assess the client further.
- 2. Measure the client's blood pressure and heart rate.
- 3. Call for help and place the client in a wheelchair.
- 4. Administer nitroglycerin.

127. The nurse is counseling a client about the prevention of coronary heart disease. Which of the following vitamins should the nurse recommend the client include in his diet to reduce homocysteine levels? Select all that apply.

- 1. Vitamin K.
- 2. Vitamin B₆.
- 3. Folate.
- 4. Vitamin B₁₂.
- 5. Vitamin D.

128. The nurse evaluates a client's knowledge as deficient when the client makes which of the following statements about the drug dexamethasone (Decadron)?

- 1. "I cannot stop the Decadron all at one time."
- 2. "If I forget a dose, it's no big deal; I'll just take it when I remember it."
- 3. "When I get a cold, I need to let my doctor know."
- 4. "I need to watch for an allergic reaction when I first start taking Decadron."

129. A 3-month-old is admitted to the pediatric unit with moderate dehydration. The nurse should assess the client for:

- 1. Oliguria.
- 2. Rapid, thready pulse.
- 3. Decreased skin elasticity.
- 4. Pale skin color.

130. The nurse is assessing a client who is suspected of being in the early symptomatic stages of human immunodeficiency virus (HIV) infection. Which of the following signs and symptoms of infection should the nurse detect during this stage?

- 1. Whitish yellow patches in the mouth.
- 2. Dyspnea.
- 3. Bloody diarrhea.
- 4. Raised, hyperpigmented lesions on the legs.

131. A primiparous client who is breast-feeding develops endometritis on the third postpartum day. Which of the following instructions should the nurse give to the mother?

- 1. The neonate will need to be bottle-fed for the next few days.
- 2. The condition typically is treated with I.V. antibiotic therapy.
- 3. The client's uterus may become "boggy," requiring frequent massage and oxytocics.
- 4. The client needs to remain in bed in a side-lying position as much as possible.

132. After instructing a primiparous client who is breast-feeding on how to prevent nipple soreness during feedings, the nurse determines that the client needs further instruction when she states which of the following?

- 1. "I should position the baby the same way for each feeding."
- 2. "I should make sure the baby grasps the entire areola and nipple."
- 3. "I should air dry my breasts and nipples for 10 to 15 minutes after the feeding."
- 4. "I shouldn't use a hand breast pump if my nipples get sore."

133. A client who has Ménière's disease is experiencing an acute attack of vertigo. Which of the following interventions should the nurse include in the plan of care?

- 1. Darken the client's room and provide a quiet environment.
- 2. Provide a low-sodium, bland diet.
- 3. Administer an opioid to relieve headache.
- 4. Encourage fluid intake to prevent dehydration.

134. During a home visit to a primiparous client 1 week postpartum who is bottle-feeding her neonate, the client tells the nurse that her mother has suggested that she feed the neonate cereal so he will sleep through the night. Which of the following would be the nurse's **best** response?

- 1. "It is permissible to give the baby cereal if it is thinned with formula."
- 2. "The time for starting cereal varies, so check with your pediatrician."
- 3. "Formula is the food best digested by the baby until about 4 to 6 months of age."
- 4. "If cereal is given too early in life, the undigested food can lead to a need for surgery."

135. When a client states that he is allergic to amoxicillin (Ampicillin) even though his medication administration record and armband do not indicate medication allergies, the nurse should:

- 1. Administer the prescribed medication.
- 2. Withhold the amoxicillin (Ampicillin).
- 3. Administer another, similarly acting antibiotic.
- 4. Call the family to verify the client's statement.

136. While assessing a term neonate on a home visit to a primiparous client 2 weeks after a vaginal delivery, the nurse observes that the neonate is slightly jaundiced and the stool is a pale, light color. The nurse notifies the physician because these findings indicate which of the following?

- 1. Biliary atresia.
- 2. Rh isoimmunization.
- 3. ABO incompatibility.
- 4. Esophageal varices.

137. A 6-year-old child has had heart surgery to repair tetralogy of Fallot. When developing the discharge plan, the nurse should include information about:

- 1. Allowing the child to lead a normal, active life.
- 2. Persuading the child to get enough rest.
- 3. Having the child develop postoperative complications.
- 4. Having the child out of school for a month.

138. A client is recovering from abdominal surgery and has a nasogastric (NG) tube inserted. The expected outcome of using the NG tube is gastrointestinal tract?

- 1. Compression.
- 2. Lavage.
- 3. Decompression.
- 4. Gavage.

139. The nurse teaches the mother of a toddler who has had cleft palate repair that her child is at risk for developing which of the following in the future?

- 1. Hearing problems.
- 2. Poor self-concept.
- 3. A speech defect.
- 4. Chronic sinus infections.

140. The nurse assesses a client who is receiving a tube feeding. Which of the following situations would require prompt intervention from the nurse?

- 1. The client is sitting upright in bed while the feeding is infusing.
- 2. The feeding that is infusing has been hanging for 8 hours.
- 3. The client has a gastric residual of 25 mL.
- 4. The feeding solution is at room temperature.

141. A client has been taking furosemide (Lasix) for 2 days. The nurse should assess the client for:

- 1. An elevated blood urea nitrogen (BUN) level.
- 2. An elevated potassium level.
- 3. A decreased potassium level.
- 4. An elevated sodium level.

142. When suctioning the respiratory tract of a client, it is recommended that the suctioning period not exceed how many seconds?

- 1. 5 seconds.
- 2. 10 seconds.
- 3. 15 seconds.
- 4. 20 seconds.

143. An 80-year-old client with severe kidney damage is placed on life support and dialysis. Care decisions are being made by his wife, who is showing signs of early Alzheimer's disease. The client's daughter arrives from out of town with a copy of the client's living will, which states that the client did not want to be on life support. The nurse should:

- 1. Immediately inform the physician about the living will.
- 2. Suggest to the daughter that she discuss her father's wishes with her mother.
- 3. Prepare to remove the client from life support.
- 4. Make a copy of the living will and give it to the client's wife.

144. Prior to administering plasminogen activator (t-PA) to a client admitted with a stroke, the nurse should verify that the client: Select all that apply.

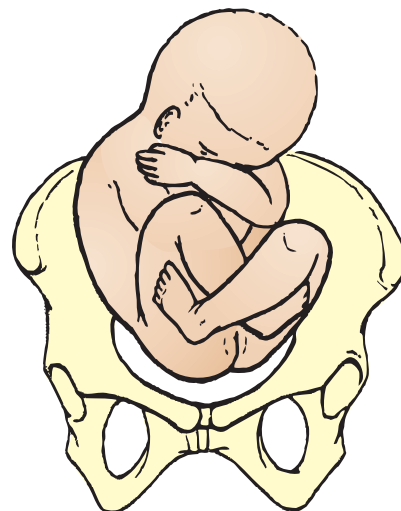
- 1. Is older than 65 years.
- 2. Has had symptoms of the stroke less than 3 hours.
- 3. Has a blood pressure within normal limits.
- 4. Does not have active internal bleeding.
- 5. Has not had an alcoholic beverage within the last 8 hours.

145. When caring for a client with myasthenia gravis who is receiving anticholinesterase drug therapy, the nurse must be able to distinguish cholinergic crisis from myasthenic crisis. Which of the following symptoms is not present in cholinergic crisis?

- 1. Improved muscle strength after I.V. administration of edrophonium chloride (Tensilon).
- 2. Increased weakness.
- 3. Diaphoresis.
- 4. Increased salivation.

146. The nurse identifies the type of presentation shown in the figure as which of the following?

- 1. Frank breech.
- 2. Compound breech.
- 3. Complete breech.
- 4. Incomplete breech.



147. Which of the following client statements indicates that the client with hepatitis B understands his discharge teaching?

- 1. "I will not drink alcohol for at least 1 year."
- 2. "I must avoid sexual intercourse."
- 3. "I should be able to resume normal activity in a week or two."
- 4. "Because hepatitis B is a chronic disease, I know I will always be jaundiced."

148. Which of the following examples should the nurse use to describe bulimia to a group of parents at a local community center?

- 1. An adolescent male who uses calorie-counting to maintain his weight in the desirable range for his height.
- 2. A college-age male who uses regular exercise to be able to eat and drink what he wants without gaining weight.
- 3. A middle-aged female who uses diet pills occasionally to help her lose 10 lb.
- 4. A college-age female who binges and then purges to prevent weight gain.

149. A client who has been taking diazepam (Valium) for 3 months for skeletal muscle spasms and lower back pain states that he stopped taking the medication 2 days ago because it was no longer helping him, but now he feels terrible. The nurse should assess the client for which of the following? Select all that apply.

- 1. Insomnia.
- 2. Euphoria.
- 3. Bradycardia.
- 4. Diaphoresis.
- 5. Tremor.
- 6. Vomiting.

150. An I.V. infusion is to be administered through a scalp vein on an infant's head. What should the nurse tell the parents to prepare them for the procedure?

- 1. It may be necessary to remove a small amount of hair from the infant's scalp.
- 2. A sedative will be given to help keep the infant quiet.
- 3. Visiting the infant will be delayed until the infusion has been completed.
- 4. Holding the infant will be contraindicated while the infusion is being administered.

151. Which of the following goals is **most** important for a client with acute pancreatitis?

- 1. The client reports minimal abdominal pain.
- 2. The client regains a normal pattern for bowel movements.
- 3. The client limits alcohol intake to two to three drinks per week.
- 4. The client maintains normal liver function.

152. A nurse is caring for a child with diabetes mellitus at camp. The child is irritable and has a headache. Which of the following should the nurse do **first**?

- 1. Administer 2 oz of orange juice.
- 2. Notify the physician about the child's status.
- 3. Check the child's blood glucose level.
- 4. Send the child back to the planned activities.

153. A client tells the nurse that her bra fits more snugly at certain times of the month and she is concerned this may be a sign of breast cancer. The **best** response for the nurse is to explain that:

- 1. A change in breast size should be checked by her physician.
- 2. Benign cysts tend to cause the breast to vary in size.
- 3. It is normal for the breast to increase in size before menstruation begins.
- 4. A difference in the size of her breasts is related to normal growth and development.

154. Which of the following is an example of beliefs of traditional Chinese medicine found in Asian-American culture?

- 1. Health is described as harmony between family members.
- 2. Illness is caused by an imbalance of the yin and yang.
- 3. Exercise to the point of overexertion can improve health.
- 4. Illness is caused by a change in eating habits.

155. A client is scheduled for an intravenous pyelogram (IVP). Which of the following questions would be **most** important for the nurse to ask the client in preparation for the procedure?

- 1. "Have you ever had an IVP before?"
- 2. "Do you have any allergies to shellfish?"
- 3. "When was your last bowel movement?"
- 4. "Have you ever experienced urinary incontinence?"

156. Which oral contraceptive is considered safe for use while breast-feeding because it will not affect the breast milk or breast-feeding?

- 1. Estrogen.
- 2. Estrogen and progestin.
- 3. Progestin.
- 4. Testosterone.

157. A multigravid client at 36 weeks' gestation who is visiting the clinic for a routine visit begins to sob and tells the nurse, "My boyfriend has been beating me up once in a while since I became pregnant—but I can't bring myself to leave him because I don't have a job and I don't know how I would take care of my other children." Which of the following actions should be the **priority** by the nurse at this time?

- 1. Contact a social worker for assistance and family counseling.
- 2. Help the client make concrete plans for the safety of herself and her children.
- 3. Tell the client that she shouldn't allow anyone to hit her or her children.
- 4. Provide the client with brochures on the statistics about violence against women.

158. Sulfadiazine has been ordered for a client who has a urinary tract infection. Which of the following nursing interventions is **most** appropriate for administering sulfonamides?

- 1. Encourage the client to take the medication with meals.
- 2. Instruct the client to drink at least 8 glasses of water a day.
- 3. Measure the client's urine output.
- 4. Instruct the client that the urine may turn reddish orange.

159. A client with chronic undifferentiated schizophrenia is having an acute exacerbation of symptoms. The client states, "Black cats and black hats. Where does the time go?" Which of the following would be **most** important for the nurse to say?

- 1. "Halloween is getting close, isn't it."
- 2. "Do you have a black cat?"
- 3. "What's the connection between cats, hats, and time?"
- 4. "Time certainly does go faster these days."

160. A client has been diagnosed with multi-infarct (or vascular) dementia (MID). When preparing a teaching plan for the client and family, which of the following should the nurse indicate as the **most** critical factor for slowing MID?

- 1. Administering anticoagulants such as warfarin (Coumadin).
- 2. Administering benzodiazepines such as lorazepam (Ativan) to decrease choreiform movements.
- 3. Managing related symptoms such as depression.
- 4. Managing the symptoms by increasing dopamine availability.

161. While performing cardiopulmonary resuscitation (CPR) on a 5-year-old child, the nurse palpates for a pulse. Which of the following sites is **best** for checking the pulse during CPR in a 5-year-old child?

- 1. Femoral artery.
- 2. Carotid artery.
- 3. Radial artery.
- 4. Brachial artery.

162. A nurse is assessing a client with nephrotic syndrome. The nurse should assess the client for which condition?

- 1. Hematuria.
- 2. Massive proteinuria.
- 3. Increased serum albumin level.
- 4. Weight loss.

163. A child with tetralogy of Fallot and a history of severe hypoxic episodes is to be admitted to the pediatric unit. Which of the following would be **most** important for the nurse to have at the bedside?

- 1. Morphine sulfate in a syringe ready to administer.
- 2. Oxygen tubing and gauge plugged in.
- 3. Blood pressure cuff and stethoscope.
- 4. Suction tubing and equipment.

164. Which statement would **most** likely be made by a Mexican-American client with pain?

- 1. "Enduring pain is a part of God's will."
- 2. "This pain is killing me."
- 3. "I've got to see a doctor right away."
- 4. "I can't go on in pain like this any longer."

165. A client tells the nurse that he is voiding small amounts of urine every 30 to 60 minutes. Which of the following actions is the nurse's **first** priority?

- 1. Palpate for a distended bladder.
- 2. Catheterize the client for residual urine.
- 3. Request a urine specimen for culture.
- 4. Encourage an increased fluid intake.

166. Which of the following has the **highest** priority in the care of a client with chronic renal failure?

- 1. Apply corticosteroid creams to relieve itching.
- 2. Achieve pain control with analgesics.
- 3. Maintain a low-sodium diet.
- 4. Measure abdominal girth daily.

167. The father of an 18-month-old with no previous illness, who has been admitted to a surgery center for repair of an inguinal hernia, tells the nurse that his child is having trouble breathing. The father does not think the child choked. After telling the clerk to call the rapid response team, the nurse should do which of the following? Place in order from first to last.

1. Notify the surgeon

2. Start an intravenous infusion.

3. Assess the effectiveness of the abdominal thrusts.

4. Perform the abdominal thrust maneuver.

5. Listen for breath sounds.

168. The nurse is assessing a child's skeletal traction and notices that the weights are on the floor. Which of the following should the nurse do **next**?

- 1. Raise the weights so that the child can move up in bed.
- 2. Notify the physician immediately.
- 3. Put the foot of the bed on blocks.
- 4. Move the child up in bed.

169. Compared to the food requirements of preschoolers and adolescents, the food requirements of school-age children are not as great because these children have a lower:

- 1. Growth rate.
- 2. Metabolic rate.
- 3. Level of activity.
- 4. Hormonal secretion rate.

170. When assessing a 17-year-old client with depression for suicide risk, which of the following questions would be **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?"
- 4. "Are you thinking about killing yourself?"

171. Which of the following is a major risk factor for having a low-birth-weight baby?

- 1. Heredity.
- 2. Age.
- 3. Drug use during pregnancy.
- 4. Poor nutrition.

172. Which of the following techniques is **best** for the nurse to use in evaluating the parents' ability to administer eardrops correctly?

- 1. Observe the parents instilling the drops in the child's ear.
- 2. Listen to the parents as they describe the procedure.
- 3. Ask the parents to list the steps in the procedure.
- 4. Ask the parents whether they have read the handout on the procedure.

173. Ibuprofen (Motrin) is prescribed for a client with osteoarthritis. Which of the following instructions about ibuprofen should the nurse include in the client's teaching plan?

- 1. Report the development of tinnitus.
- 2. Increase vitamin B₁₂ intake.
- 3. Take with food or antacids.
- 4. Have the complete blood count (CBC) monitored monthly.

174. A staff member states, "I don't know why Mary is so depressed. She lives in an exclusive part of town and has gorgeous clothes. Her husband seems to care about her very much. She really has it all." Which of the following should the nurse conclude from the staff member's statement?

- 1. An accurate assessment of the client has been made.
- 2. The staff member is jealous of the client.
- 3. There is no reason for the client to be depressed.
- 4. The staff member needs teaching about major depression.

175. The nurse is instructing the mother of a child with asthma about noting food triggers for asthma attacks. Which of the following foods would **most** likely be responsible for causing an allergic reaction?

- 1. Whitefish.
- 2. Tossed salad.
- 3. Hamburger.
- 4. Fudge brownies.

176. When preparing to administer a tap water enema, in which position should the nurse place the client?

- 1. Supine.
- 2. Semi-Fowler's.
- 3. Right lateral.
- 4. Left Sims.

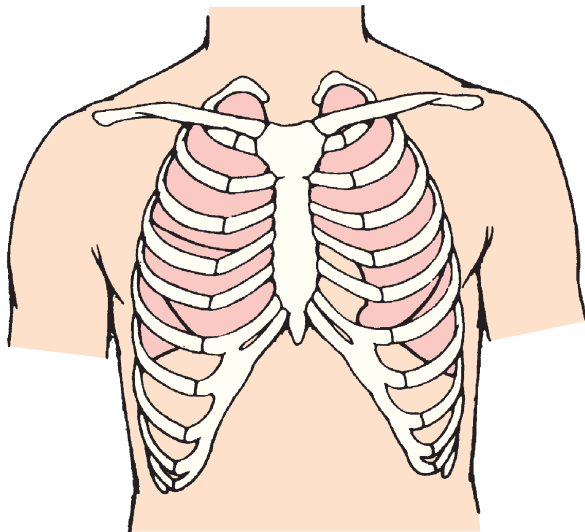
177. Which of the following is a risk factor for the development of pressure ulcers?

- 1. Ambulating less than twice a day.
- 2. An indwelling urinary catheter.
- 3. Decreased serum albumin level.
- 4. Elevated white blood cell count.

178. A 42-year-old woman was admitted to the hospital with a hemoglobin of 6.5 g/dL. She is experiencing signs and symptoms of cerebral tissue hypoxia. The nurse should:

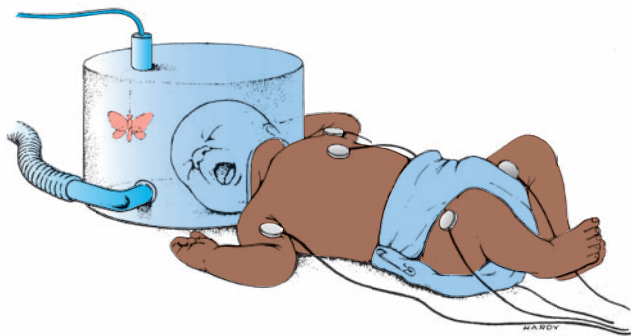
- 1. Plan frequent rest periods throughout the day.
- 2. Assist the client in ambulating to the bathroom.
- 3. Check the temperature of the water before the client showers.
- 4. Refer the client to occupational therapy for energy conservation interventions.

179. A nurse is assessing an older adult with pneumonia. Where should the nurse place the stethoscope to listen for breath sounds that will indicate the client is fully oxygenating the lung on the right side?



180. The nurse is giving care to an infant in an oxygen hood (see figure). The nurse should do which of the following. Select all that apply.

- 1. Assure that the oxygen is not blowing directly on the infant's face.
- 2. Place the butterfly mobile on the outside of the hood.
- 3. Immobilize the infant with restraints.
- 4. Remove the hood for 10 minutes every hour.
- 5. Encourage the parents to visit the child.



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. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

1. 1. The colleague needs to provide the nurse with information about spouse abuse. Giving information about reasons for staying is useful for decreasing the nurse's frustration. Although expressing empathy is appropriate, it does not help the nurse understand the client's needs and behaviors. Telling the nurse that there will be another chance is not helpful and fails to educate the other nurse about the dynamics of abuse. Although dependence is a problem, women who are abused can overcome this and leave if they have support, not criticism. Saying that abused women almost never leave does not help the nurse understand the client's needs and behaviors.

🔑 CN: Psychosocial adaptation;
CL: Synthesize

2. 1 mL

First, convert micrograms to milligrams:

$$200 \text{ mcg} = 0.2 \text{ mg.}$$

Then:

$$0.2 \text{ mg}/X \text{ mL} = 0.2 \text{ mg}/1 \text{ mL}$$

$$X = 1 \text{ mL.}$$


🔑 CN: Pharmacological and parenteral therapies; CL: Apply

3. 3. Viral gastroenteritis may be communicable, and all of the other children are already at risk for infection. The infant should be placed in a private room.


🔑 CN: Safety and infection control;
CL: Synthesize

4. 1. The neonate would be considered large for gestational age (LGA) because the neonate weighs more than 4,000 g (90th percentile). Therefore, the nurse needs to assess for the possibility of complications. Hypoglycemia is a problem for the LGA neonate because glycogen stores are quickly used to maintain the weight. Other common complications for an LGA neonate include hyperbilirubinemia from the bruising and polycythemia, cephalhematoma, caput succedaneum, molding, phrenic nerve paralysis, and a fractured clavicle. However, hyperbilirubinemia would not be evident 1 hour after

birth. Hypercalcemia is not usually found in the LGA neonate. Hypocalcemia is common in infants of diabetic mothers. Hypermagnesemia may occur in neonates whose mothers received large doses of magnesium sulfate to treat severe preeclampsia.

 CN: Physiological adaptation;
CL: Analyze

5. 2. Ovarian enlargement, hyperstimulation syndrome, febrile reaction, and multiple pregnancies are considered adverse effects of menotropins. If ovarian enlargement occurs, the drug should be discontinued to prevent damage to the ovary. Pulmonary edema is not associated with menotropin use. Visual disturbances and breast tenderness are associated with the use of clomiphene citrate (Clomid), another drug prescribed for infertility.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


6. 1. Organ and Tissue Procurement Organizations are responsible for organ recovery in the United States. These organizations have offices in major cities, and provide services on a local, state, and regional basis. The agency is the repository for information about tissues and organs and their distribution. The American Transplant Association coordinates recipients of transplants. The American Hospice Foundation is involved with hospice care. The American Association of Critical-Care Nurses is involved with professional critical care nurses.

 CN: Management of care; CL: Apply

7. 3. Fluid accumulates in the base of the pleura postoperatively. The lower chest tube, called the posterior or lower tube, will drain serous and serosanguineous fluid that accumulates as a result of the surgical procedure. A larger-diameter tube is usually used for the lower tube to ensure drainage of clots. Air rises, and the anterior or upper tube is used to remove air from the pleural space. The practice of “milking” the tubes to prevent clots is becoming less common; the surgeon’s orders must be followed regarding this procedure.

 CN: Physiological adaptation; CL: Apply


8. 1. Elderly clients are a high-risk group for depression. The classic symptoms of depression frequently are masked, and depression presents differently in the aging population. Depression in late life is underdiagnosed because the symptoms are incorrectly attributed to aging or medical problems. Impairment of cognition in a previously well elderly client or psychosomatic complaints may be the presenting symptom of depression. Antidepressant therapy is usually effective.

 CN: Psychosocial adaptation;
CL: Analyze


9. 4. Fears of the adolescent include body changes and loss of control. The young adolescent is typically concerned about the inability to control body changes and feelings and about embarrassment. The typical adolescent is more concerned about being separated from the peer group than from the family and schoolwork and is realistically worried about experiencing pain and loss of control. The adolescent may prefer to wear her own clothes, but this is not a primary concern. The nurse should respect the client’s privacy, but this is not a primary concern for this client.

 CN: Health promotion and maintenance;
CL: Apply

10. 2. The mother’s statements reveal that she is having problems with parenting. Therefore, a referral to a parenting education program is the most appropriate measure at this time.

 CN: Psychosocial adaptation;
CL: Synthesize


11. 2. The infant who has not eaten in 4 hours is the highest priority of this group of couplets. The last feeding was 4 hours ago and the prior poor feeding puts this infant at risk. An assessment of this infant is needed from a safety perspective since the mother had magnesium sulfate. The nurse should question whether the poor feeding may be a result of magnesium sulfate in the newborn’s system by evaluating respiratory rate, tone, and current ability to feed. The couplet with an infant with TTN and a respiratory rate of 60 is within normal limits but should have the respiratory rate reevaluated to assure normalcy. The mother who had a Cesarean section should be evaluated to determine when she will be able to go to SCN to see her infant. Urgency concerning taking her to the nursery will also depend on the condition of the newborn. The newborn of 36 weeks’ gestation is currently within normal blood glucose range, but would need to be monitored frequently because of the small infant size and prior low blood glucose.

 CN: Management of care;
CL: Synthesize

12. 2. The nurse acts in a reasonable and prudent manner to correctly identify a client by checking the client’s armband and asking the client’s name. Omitting to do so is an act of negligence. *Res judicata* and *stare decisis* are legal doctrines used to guide the courts in making decisions. Vicarious liability is a concept in which the employer is held liable for the nurse’s act. It was established after precedent-setting cases in the 1960s.

 CN: Health promotion and maintenance;
CL: Apply

13. 2. Morphine can cause respiratory depression, leading to respiratory arrest. The nurse should assess the client's respiratory rate before administration and throughout the course of analgesic treatment. Morphine does not affect blood pressure, pulse rate, or temperature.

 CN: Pharmacological and parenteral therapies; CL: Analyze


14. 21 gtt/minute

One unit of packed red blood cells contains 250 mL, and this is to infuse over 2 hours (120 minutes). First, determine the number of mL/minute by dividing 250 mL by 120 minutes:

$$250/120 = 2.1 \text{ mL/minute.}$$

Then multiply by the drop factor of 10 gtt/mL:

$$2.1 \times 10 = 21 \text{ gtt/minute.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


15. 1. Anger is a natural result of feelings of loss and helplessness in normal, healthy people. It is a natural response to coping with a sick child. Nurses should recognize anger in clients and families. Parents are usually able to control their anger in a socially acceptable manner. Nurses can assist clients and families to overcome helplessness and anger in an acceptable manner.

 CN: Psychosocial adaptation;
CL: Synthesize


16. 3. Supervised activities that promote walking are behavioral management strategies that help a client such as this. The client's cognitive and memory impairment would not be conducive to playing board games. Allowing the behavior at selected intervals would further encourage the client to wander. The client should not be restrained in a chair.

 CN: Psychosocial adaptation;
CL: Synthesize


17. 3. With a new complaint of numbness in the fingers, the nurse needs to first assess the circulation to evaluate color, evidence of swelling, and presence of pulses to determine whether there is any circulatory compromise. Once the nurse had evaluated the child's circulatory status, the next action would be to verify the arm's position above the level of the heart. Notifying the physician would not be done until the child's neurovascular status and position are checked. Cutting the cast would be done only with a physician's order.

 CN: Physiological adaptation;
CL: Synthesize


18. 3. LBP is commonly associated with overuse or an injury to the soft-tissue structures. It is estimated that 50% to 70% of people will experience musculoskeletal back pain at some time. Although the other causes of pain must be excluded, the initial treatment of LBP is usually aimed at decreasing the inflammatory response to the tissue injury.

 CN: Physiological adaptation;
CL: Analyze


19. 2. At the time of a major crisis, the client suffering a great loss is best helped by being encouraged to talk about his experience and describe his feelings. Crisis interventions focus on reestablishing emotional equilibrium and preventing decompensation. Telling the client that everything will be fine is a cliché and inappropriate. Asking the client to stop talking so that the nurse can write notes places more emphasis on the nurse's needs than on the client's needs. Telling the client to think more about what happened for further discussion the next day is not helping him with the crisis.

 CN: Psychosocial adaptation;
CL: Synthesize

20. 2. Beclomethasone is an inhaled steroid used for the maintenance treatment of asthma. The steroid can precipitate overgrowth of fungus, such as oral *Candida albicans*. Rinsing the mouth well after each use decreases the incidence of oral fungal infections. Beclomethasone does not cause gingival hyperplasia, ulceration, or caries.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

21. 1. The incident report should be given to the nurse-manager. The incident report should not be placed on the chart because it is considered a confidential communication and cannot be subpoenaed by a client or used as evidence in lawsuits. It is appropriate, ethical, and legally required that the fall be documented in the chart. Unless there is a change in the client's condition reflecting an injury from the fall, there is no need to notify the family. If the family does need to be notified, the nurse-manager or the physician should place the call.


 CN: Management of care; CL: Synthesize

22. 2. The 22-year-old G2 with urinary retention and needing to be I & O catheterized by a health care provider can be cared for by the LPN. There is nothing else indicating a need for a higher level of care. The newly admitted G5 client is in need of an admission assessment and assessment of fetal well-being and bleeding which will need to be done by an RN. The G4 P2 with a twin pregnancy who has been in preterm labor can be cared for by a UAP since there is no active labor and no indication of distress in the


fetuses. The client in sickle cell crisis requires a high level of care to be provided by an RN.

 CN: Management of care; CL: Synthesize


23. 2. General wound care is appropriate initially. This includes washing the bite area with lots of water because infections occur frequently with animal bites, especially those on the arms or hands. Next, the mother should be advised to determine the extent of the injury and then to follow-up with the child's physician if needed. A trip to the local care center would be warranted if the bite injury was extensive or there was severe bleeding. Although knowledge of when the child last had a tetanus vaccination is important, the child's wound takes priority. For rabies injections, there needs to be a history of rabies or unusual behavior in the pet.

 CN: Physiological adaptation;
CL: Synthesize

24. 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 to prevent 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


25. 2. Chemoprophylaxis should be given to household contacts and close contacts only. To prevent community outbreaks, chemoprophylaxis with rifampin 600 mg twice a day for 2 days or a single dose of Cipro 500 mg is indicated.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


26. 2. Infants and toddlers younger than age 2 should not be placed on a fat-restricted diet because cholesterol and other fatty acids are required for continued neural growth. After age 2 it is believed that no harm is done by encouraging a child to eat a variety of foods, maintain a desirable body weight, limit saturated fat and cholesterol, and increase fiber.

 CN: Health promotion and maintenance;
CL: Apply


27. 1. Petroleum jelly is thought to smother the lice. A pediculicide should not be applied to the face or close to the eyes. Bacitracin ointment will not kill the lice.

 CN: Pharmacological and parenteral therapies; CL: Apply


28. 1. A major goal of safety and accident prevention focuses on having all cleaning supplies and medications locked up. Toddlers are great climbers and can very quickly get into what they should not. The child should not play in the bathroom even if the parent is present because the child will think that it is okay to play with these items when the parent is not present. Playing with cords could lead to possible strangulation. The child-protective cabinet locks should work unless they were installed incorrectly or are defective.

 CN: Safety and infection control;
CL: Evaluate

29. 3, 4, 5. Common adverse effects of tobramycin include nephrotoxicity, ototoxicity, fever, and rash. Hypertension, weight gain, and decreased heart rate are not associated with this drug.

 CN: Pharmacological and parenteral therapies; CL: Analyze


30. 4. Fever is generally not thought to be a sign of impaired renal function related to long-term use of gentamicin. The client should report signs of decreasing urinary function, such as decreased output, unusual appearance of the urine, or edema.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

31. 4. Plastic blocks are the most appropriate toy for a toddler in a mist tent. Because the blocks are plastic, they can be washed. For the pull toy to be used, the child would need to leave the mist tent, which is not advisable at this time. Although crayons may be appropriate for a mist tent, any paper, including storybooks, would become damp, crumble, and provide an environment for the growth of microorganisms.

 CN: Health promotion and maintenance;
CL: Synthesize

32. 2. Febrile seizures commonly occur as the fever rises. The exact cause of febrile convulsions is not known. Infants and young toddlers are the age-groups primarily affected. Febrile seizures typically do not follow immunization administration.


 CN: Health promotion and maintenance;
CL: Apply

33. 1, 2, 4, 6. The nurse case manager should refer the client to a nutritionist so the client is aware of and can be monitored regarding her food intake to assure transition to a normal pregnancy diet with intake of adequate nutrients to support growth and development of the fetus. A p.r.n. (as needed) prescription for an antiemetic is useful to overcome occasional episodes of nausea and vomiting. Encouraging a return to normal activities when the client feels ready gives the client a goal to look forward to and activity is not contraindicated in


hyperemesis when the client feels ready it initiate activity. Discussion of the plan of care and discharge instructions is a standard of care when discharging a client from a health care facility. There is no indication for an anxiolytic and hyperemesis gravidarum typically is not associated with anxiety. Six weeks is too long to wait for a follow-up appointment post hospitalization.

 CN: Health promotion and maintenance;
CL: Create


34. 4. Oral contraceptive use, pregnancy, and lactation are situations that increase demand for folic acid. With supplementation, a response should cause the reticulocyte count to increase within 2 to 3 days after therapy has begun. It is not necessary to take folic acid on an empty stomach. A client may safely take both iron and folic acid supplementation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


35. 4. Although acrocyanosis may be present for 24 to 48 hours after birth, central cyanosis of the trunk indicates decreased oxygenation from respiratory distress or another disease state (e.g., cardiac anomalies). This should be reported to the physician and evaluated further. Maternal lochia serosa in scant amount is a normal finding 1 week postpartum, as is a nonpalpable maternal fundus. Presence of a neonatal tonic neck reflex is a normal finding in a 1-week-old neonate.

 CN: Physiological adaptation;
CL: Analyze

36. 1, 2, 3, 4. The nurse should ask the client about alcohol use, because heavy alcohol use causes fluid excretion resulting in heavy losses of calcium in urine. If the client uses antacids containing aluminum or magnesium, a net loss of calcium can occur. If the client has a high-fiber diet, the fiber can bind up some of the dietary calcium. People with hip fractures have been found to have low vitamin K intakes; vitamin K plays an important role in production of at least one bone protein. Fruit juices do not affect calcium absorption.

 CN: Health promotion and maintenance;
CL: Analyze


37. 1. The postrape examination is important for detecting the possibility of sexually transmitted disease, which can be spread through rape. Additionally, if the victim or the rapist was not using a contraceptive, postcoital contraceptive methods should be discussed. The information provided does not indicate anxiety or physical injury, such as periurethral tears, and these are not the primary reason for the examination. Menstrual difficulties are not a common result of rape.

 CN: Safety and infection control;
CL: Synthesize

38. 3. The nurse should question the use of a local anesthetic agent with epinephrine on the hands or feet because the epinephrine is a vasoconstrictor and can cause ischemia and gangrene of extremities. The nurse should suggest that the intern use bupivacaine (Marcaine) without epinephrine as the local anesthetic agent. An intern should be trained in suturing small superficial incisions, and the cosmetic effect should be acceptable. The client's room should be a sufficiently aseptic environment because there is no other client in the room.

 CN: Management of care;
CL: Synthesize

39. 2. Chills are a normal response of the body's immune system to infection and are not a response of the sympathetic nervous system to pain. Tachycardia, increased respiratory rate, and dilated pupils are sympathetic effects.

 CN: Physiological adaptation;
CL: Evaluate


40. 3. In dark-skinned clients, cyanosis can best be detected by examining the conjunctiva, lips, and oral mucous membranes. Examining the retinas, nail beds, or inner aspects of the wrists is not an appropriate assessment for determining cyanosis in any client.

 CN: Health promotion and maintenance;
CL: Analyze

41. 7.5 mL

$$0.9 \text{ mg}/X \text{ mL} \times 0.6 \text{ mg}/5 \text{ mL}$$


$$X = 7.5 \text{ mL}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

42. 1. A biophysical profile includes a nonstress test; evaluation of fetal breathing movements, gross body movements, and fetal tone; and amniotic fluid volume measurement. Because an ultrasound analysis is used during the test, the client should plan to drink 1 to 2 L of fluid before the test to ensure a full bladder, which provides better visualization of the fetus. The client does not need to be on nothing-by-mouth status before the test. The client does not need to remain in the clinic for 4 hours after the test. However, if the client were scheduled for a contraction stress test, she would be observed as an outpatient for 1 to 4 hours after the test to make certain that the contractions had stopped. The client does not need to eat a high-fiber meal after the test. A high-fiber meal typically is indicated after certain radiographic procedures, such as an upper gastrointestinal series.

 CN: Reduction of risk potential;
CL: Apply

43. 1, 2, 4, 5. Children typically act out their feelings (such as depression and anger) in response to incest. Sexualized play, aggression, running away, and truancy are typical acting-out behaviors. Isolation at home is not common for incest victims who are preadolescents.

 CN: Psychosocial adaptation;
CL: Analyze


44. 1, 3, 4. Delegation involves the re-assignment or transfer of selected aspects of a job to selected persons in selected situations. Although responsibility for completion of a task or activity can be delegated, accountability for that task remains with the RN. In delegating nursing acts, functions, or tasks, the RN must consider the nursing model to determine the appropriate delegation of assignment. Prior to delegation, the RN validates that the non-RN caregiver has orientation and experience in completion of the activity. The amount of time the nurse has does not direct the delegation procedure; the focus is on the task and capability of the staff to whom the task is delegated. It is not necessary to document that the task has been delegated and to whom; however, the outcome of the task should be documented by the nurse.

 CN: Management of care; CL: Apply

45. 2. About 25% of the teenager's diet can come from snacks. This is a way for teenagers to obtain protein, thiamine, riboflavin, vitamin B₆, magnesium, and zinc. Although not all snacks are low in fat or contain these nutrients, the nurse should encourage the mother to provide snacks with these nutrients.

 CN: Health promotion and maintenance;
CL: Apply

46. 3. Applying a water-soluble lubricant to the nares helps alleviate sore nares when an NG tube is in place. Repositioning the tube does not eliminate the possibility of irritating the nares. Irrigating the tube with a cool solution or changing positions will not relieve the local irritation from the NG tube.


 CN: Basic care and comfort;
CL: Synthesize

47. 1, 5. Hindus do not eat beef. Sufficient protein can be obtained from lentils and fish.


 CN: Health promotion and maintenance;
CL: Synthesize

48. 3. Although monitoring vital signs frequently is important, for the first few days the primary concern in burn care is fluid and electrolyte balance, with the goal being to replace fluid and electrolytes lost. With burns, fluid and electrolytes move from the interstitial spaces to the burn injury and are


lost. These must be replaced. Once the child's fluid and electrolyte status has been addressed and fluid resuscitation has begun, preventing wound infection is a priority and efforts to control the child's pain can be initiated.

 CN: Physiological adaptation;
CL: Synthesize


49. 2. Inactivated polio vaccine is given intramuscularly, usually with other vaccines. A killed virus is given to immunocompromised children.

 CN: Pharmacological and parenteral therapies; CL: Apply


50. 2, 3, 4. Diphenhydramine hydrochloride is an antihistamine that blocks the effects of histamine at receptor sites and has atropine-like effects, such as dry mouth, nausea, drowsiness, tachycardia, and thickened bronchial secretions. Weight loss and bradycardia are not adverse effects of this medication.

 CN: Pharmacological and parenteral therapies; CL: Apply


51. 4. The nurse does not administer naloxone because naloxone is the antidote for morphine, not midazolam. The benzodiazepine-receptor antagonist for midazolam is flumazenil (Romazicon). The nurse can promote oxygenation by encouraging deep breathing and administering oxygen. Resuscitation equipment should be accessible if needed.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

52. 3. The client should be seated upright with the arms raised and crossed in front and supported by the overbed table. The client's head should rest on the arms. This position allows for outward expansion of the chest wall and promotes collection of the pleural fluid at the base of the thorax.


 CN: Reduction of risk potential;
CL: Synthesize

53. 3. Three or more servings of dairy products meet the calcium requirement. These can be obtained through milk, cheese, yogurt, and foods such as tofu. Spinach contains oxalates, which decrease the availability of calcium. Six to eleven servings of whole grains are recommended. Vitamin A supplements are not necessary in vegetarian diets because most vegetarian diets are rich in vitamin A. Vitamin A supplements can lead to anorexia, irritability, hair loss, and damage to the fetus.


 CN: Basic care and comfort;
CL: Synthesize

54. 1. Intracellular microorganisms, such as viruses and parasites, invade the myocardium to survive. These microorganisms damage the vital organelles and cause cell death in the myocardium.

The myocardium becomes weak, leading to heart failure; then T lymphocytes invade the myocardium in response to the viral infection. The T lymphocytes respond to the viral infection by secreting cytokines to kill the virus, but they also kill the virus-infected myocardium. Myocardial infarction, renal failure, and liver failure are not direct consequences of a viral or parasitic infection.

 CN: Safety and infection control;
CL: Analyze


55. 1, 2, 4. A National Patient Safety Goal of The Joint Commission is to accurately and completely reconcile medications across the continuum of care. The requirement is that there is a process for comparing the client's current medications with those ordered for the client while under the care of the health care organization. Clients are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation, and communication of an accurate medication list throughout the continuum of care are essential in the reduction of transition-related adverse drug events. The client or client's family is an integral component of medication reconciliation, particularly at the point of admission to, and discharge from, a health care facility. Any medications that the client uses, for example, over-the-counter medications, must be included in the reconciliation process.

 CN: Safety and infection control;
CL: Apply


56. 2. The compensatory mechanism for respiratory acidosis is the renal system. In respiratory acidosis, the kidneys will conserve HCO_3^- in an attempt to correct the acidosis. Excretion of HCO_3^- would exacerbate the body's acidosis. The lungs cannot compensate for a problem that arises in the respiratory system.

 CN: Physiological adaptation;
CL: Analyze

57. 2. Amiodarone is metabolized in the liver and excreted in the bile and feces. Liver toxicity has been reported with the use of this drug, so the nurse will want to monitor the client's liver enzymes. Amiodarone does not affect hemoglobin, CK, or renal function.

 CN: Pharmacological and parenteral therapies; CL: Apply

58. 2. Antibiotics are the drug of choice in treating otitis media. Antihistamines, eardrops, and cotton in the ears are not helpful and are not recommended.

 CN: Physiological adaptation;
CL: Synthesize


59. 2. Yogurt is high in protein because it is made from milk. The other choices are much higher in carbohydrates than protein except for bacon, which is higher in fat.

 CN: Reduction of risk potential;
CL: Apply


60. 3. If the gastric balloon should rupture or deflate, the esophageal balloon can move and partially or totally obstruct the airway, causing respiratory distress. The client must be observed closely. No direct action should be taken until the condition is accurately diagnosed.

 CN: Reduction of risk potential;
CL: Synthesize

61. 3. Ciprofloxacin (Cipro) does not affect the PTT. It increases the theophylline level by 15% to 30% and may increase the PT. Iron decreases the absorption of ciprofloxacin.

 CN: Pharmacological and parenteral therapies; CL: Apply

62. 3. Pediculosis capitis, or head lice, can be spread by close contact or sharing of head gear or combs and brushes with other children. Sharing craft supplies, swimming, or showering usually do not provide close enough contact to permit transmission.

 CN: Physiological adaptation;
CL: Synthesize

63. 1. In the first trimester, ultrasound scanning typically is ordered to determine the gestational age. This is especially important for a client with a history of irregular menstrual cycles to establish an accurate delivery date. There is no reason at this point in pregnancy to determine whether twins are present. This might be indicated if the fundal height were larger than the gestational age may indicate. Identifying the gender of the fetus is not a reason for an ultrasound examination unless there is a history of sex-linked genetic disorders. Pelvic adequacy can be determined by physical examination. If the client has a borderline pelvis, an ultrasound scan cannot confirm this. Pelvimetry can be done, but it is not performed as frequently as it once was.

 CN: Health promotion and maintenance;
CL: Apply

64. 2. The nurse should prepare to insert an NG tube. The data collected provide evidence that the client is experiencing an upper gastrointestinal bleed secondary to a peptic ulcer. The client will be placed on nothing-by-mouth status and an NG tube will be inserted to provide gastric decompression and alleviate vomiting. Administering antiemetics is not a priority action for a client who is hypotensive and vomiting coffee-ground emesis. Assessment of client stressors is appropriate after emergency


care has been provided and the client stabilized. A modified Trendelenburg position is inappropriate for clients who are vomiting.

 CN: Reduction of risk potential;
CL: Synthesize

65. 3. The sudden onset of bright red drainage of this magnitude needs to be further assessed. Assessing vital signs is an important nursing action to determine whether there have been any changes in the client's status. Additional steps would include reinforcing the dressing and notifying the physician. Increasing the I.V. flow rate does not address the bleeding. Changing the dressing would be done only if the physician ordered it.

 CN: Reduction of risk potential;
CL: Synthesize

66. 1. Because the client with ADHD is easily distractible, it is important to obtain eye contact before explaining the task. Simple language and having him repeat what he is told are necessary because of his age. Praise encourages the client to repeat the task in the future as well as building the client's self-esteem. A full explanation with verbal praise and a food reward is inappropriate because a food reward increases the chance that he will expect a physical reward for completing tasks. In addition, a full explanation might be too confusing for someone his age. Explaining consequences focuses on punishment, rather than praise. Although demonstration and imitation is an effective teaching method, rewarding with food fosters dependence on food reward for task completion.

 CN: Psychosocial adaptation;
CL: Synthesize

67. 1. A normal blood sugar is 70 to 110 mg/dL. Hypoglycemia causes the most immediate concern. When the brain does not have enough glucose, the client will become rapidly unconscious and, if uncorrected, seizures and death can result. A reading of 100 mg/dL is normal and no intervention is necessary. Readings of 150 and 200 mg/dL are elevated and could cause complications, but complications from the elevation would not occur as rapidly.

 CN: Reduction of risk potential;
CL: Analyze

68.


4. Maintain a patent airway.

1. Control hemorrhaging.


2. Replace fluids.

3. Relieve the client's anxiety.

The goal that has the highest priority when a client has a massive bleed from esophageal varices is to maintain a patent airway. The nurse should position the client to prevent aspiration and assess respirations and oxygen saturation. The nurse should then assist the health care provider in controlling the hemorrhage by using esophageal balloon tamponade. Octreotide (Sandostatin) may be administered to reduce portal pressure. The third priority is to restore circulating blood volume with blood and I.V. fluids. Esophageal bleeding is an anxiety-provoking event for the client and, although life-saving measures are the priority, the nurse and health care team should explain procedures to the client and provide reassurance as needed.

 CN: Physiological adaptation;
CL: Synthesize

69. 4. A client who is taking phenelzine (Nardil), a monoamine oxidase inhibitor, needs to avoid foods that are rich in tyramine because this food-drug combination can cause hypertensive crisis. The client should be given a list of foods to avoid and should report headaches, palpitations, and a stiff neck to the physician immediately. The client does not need to restrict or add salt to the diet. Drinking 10 to 12 glasses of water each day is important to teach the client who is receiving lithium therapy. Antidepressant drugs take 2 to 4 weeks to achieve therapeutic effects.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

70. 3. Clients with open fractures are particularly susceptible to infections. If not treated promptly, these infections can lead to the development of osteomyelitis. Localized symptoms of osteomyelitis include tenderness, swelling, and warmth at the site of infection, as well as unrelieved severe bone pain. Systemic symptoms include fever, chills, night sweats, and malaise. Avascular necrosis occurs when the blood supply to a bone is interrupted, most commonly in intracapsular hip fractures. Compartment syndrome is most commonly associated with fractures of the distal humerus and proximal tibia; it results from an increase in pressure on the nerves and blood supply within a closed tissue compartment. Fat embolism syndrome is associated most frequently with fractures of the long bones, ribs, and pelvis, which may or may not be open fractures.


 CN: Reduction of risk potential;
CL: Analyze

71. 4. *Impaired verbal communication* is a priority nursing diagnosis after a total laryngectomy because the client will have a tracheostomy. The client frequently requires teaching on methods of communication after surgery. *Risk for impaired*


skin integrity, Excess fluid volume, and Ineffective thermoregulation are not priority nursing diagnoses associated with a laryngectomy.

 CN: Physiological adaptation;
CL: Analyze

72. 3. The retina is especially susceptible to damage in a client with chronic hypertension. The arterioles supplying the retina are damaged. Such damage can lead to vision loss. The iris, cornea, and sclera are not affected by hypertension.

 CN: Physiological adaptation;
CL: Analyze


73. 3. Milia are white papules resulting from plugged sebaceous ducts that disappear by age 2 to 4 weeks. Parents should be instructed to avoid scratching them to prevent secondary infection. Term neonates generally have many creases on the soles of their feet. Preterm neonates may have only a few creases due to their immaturity. Strawberry hemangiomas are elevated areas formed by immature capillaries that will disappear over time. Port wine stains are deep, dark red discolorations that require laser therapy for removal. Erythema toxicum is a newborn rash or “flea bite” rash that requires no treatment and disappears over time.

 CN: Health promotion and maintenance;
CL: Synthesize

74. 4. Clients with fractures of the long bones such as the femur are particularly susceptible to fat embolism syndrome (FES). Signs and symptoms include chest pain, dyspnea, tachycardia, and cyanosis. Changes in mental status are caused by hypoxemia and can be the first symptoms noted in FES. The client can also be restless and febrile and can develop petechiae. Osteomyelitis is infection of the bone; signs and symptoms of osteomyelitis do not include respiratory symptoms. Compartment syndrome causes signs of localized neurovascular impairment, not systemic symptoms. Venous thrombosis occurs in the lower extremities and is caused by venous stasis.

 CN: Reduction of risk potential;
CL: Analyze


75. 1, 3, 4. As the homeostatic responses begin to decompensate, late clinical manifestations from a large overdose of sympathomimetic agents include loss of function of the hypothalamus such as temperature regulation, leading to profound pyrexia, and ectopic brain activity leading to seizures. Hypotension is a late sign that occurs as the vascular system collapses. Hypertension, an earlier sign, precedes hypotension. Tachycardia occurs as a reflex to hypotension, a late sign.

 CN: Pharmacological and parenteral therapies; CL: Analyze

76. 2. A small tuft of hair and an indentation at the base of the neonate’s spine is termed spina bifida occulta. This condition usually occurs between the L5 and S1 vertebrae with failure of the vertebrae to completely fuse. There are usually no sensory or motor deficits with this condition. Spina bifida cystica includes meningocele, myelomeningocele, and lipomeningocele. Meningocele is characterized by a saclike protrusion filled with spinal fluid and meninges. Usually, this condition is associated with sensory and motor deficits. Myelomeningocele is characterized by a saclike protrusion filled with spinal fluid, meninges, nerve roots, and spinal cord. With myelomeningocele, there are usually sensory and motor deficits.

 CN: Health promotion and maintenance;
CL: Analyze

77. 3, 4. The nurse should use at least two sources of identification prior to administering medication to any client, such as the medical record number and the client’s date of birth. It is not safe practice to ask the parent or a nurse to verify the correct client. It is also not safe to use the room number or crib number as a source of identification because clients’ locations in the hospital change frequently.

 CN: Safety and infection control;
CL: Apply

78. 1. The primary purpose of instilling 5 mL of normal saline solution before suctioning a tracheostomy tube is to thin the secretions to be suctioned. The saline may stimulate a cough; however, this is not the reason for using saline. The tracheostomy tube is larger than the catheter and will easily pass into the tube. Humidification is provided by a nebulizer if needed.

 CN: Reduction of risk potential;
CL: Evaluate


79. 3. The client with emphysema has a chronically elevated carbon dioxide level. As a result, the normal stimulus for breathing in the medulla becomes ineffective. Instead, peripheral pressoreceptors in the aortic arch and carotid arteries, which are sensitive to oxygen blood levels, stimulate respirations. This is in response to low oxygen levels that have developed over time. If the client receives high concentrations of oxygen, the blood level of oxygen will rise excessively, the stimulus for respiration will decrease, and respiratory failure may result. Oxygen is not cooled. Humidification or administration of the oxygen through nasal cannula will not prevent depressed ventilation if the flow rate of the oxygen is too high.

 CN: Physiological adaptation; CL: Apply


80. 1. Protein intake is a concern in all vegetarian diets. Combining two incomplete proteins to make a complete protein (with all of the essential amino acids) can improve the client's protein intake. Rice with beans or tofu provides a complete protein. Soy milk would provide vitamin D and calcium, not protein. Yogurt provides vitamin D and calcium, not sufficient protein. Corn and rice do not make up a complete protein. However, corn and beans would be a complete protein.

 CN: Basic care and comfort; CL: Apply

81. 3. The client should be encouraged to join the community arthritis support group so that she can share her feelings with others who are facing similar experiences with this chronic illness and can identify with her concerns. A hobby will not help her resolve her feelings of being alone. Seeking counseling or discussing her feelings with a minister may be helpful, but these activities will not necessarily help the client to understand that there are many individuals who must adjust their lifestyles because of arthritis and that she is not alone.

 CN: Health promotion and maintenance;
CL: Synthesize


82. 2. For the client who is unable to sit through meals to maintain adequate nutrition, the nurse should offer the client nutritious finger foods and fluids that he can consume while “on the run.” Foods high in protein and carbohydrates, such as half of a peanut butter sandwich, will help to maintain nutritional needs. Adequate fluid intake is necessary, especially if the client has been started on lithium therapy. Directing the client to his room to eat is not helpful because the client will not stay in his room long enough to eat. Asking the client's family to bring his favorite foods or asking the client about his food preferences is not helpful in ensuring adequate nutrition for the hyperactive client who is unable to sit and eat.

 CN: Psychosocial adaptation;
CL: Synthesize


83. 4. Telling the client to get her laundry and then showing her how to use the machine helps keep the client from becoming overly dependent on the nurse, establishes boundaries between the client and the nurse, and promotes positive self-worth. The statement, “Sure, I have time; I'll do it for you,” is not therapeutic because it increases the client's dependency. Telling the client that she will have to wait because the nurse doesn't have time dismisses the client and insinuates that the nurse will do the laundry later, thus fostering dependency. Asking, “Can your family do it for you?” is not appropriate because the client is capable of doing her own laundry. This statement places responsibility on the family instead of the client.

 CN: Psychosocial adaptation;
CL: Synthesize

84. 2. Early signs and symptoms of hypermagnesemia include drowsiness, lethargy, nausea, and vomiting. Flushed skin is a sign of hypernatremia. Severe thirst is associated with hyperglycemia. Tremors are associated with hypomagnesemia.

 CN: Physiological adaptation;
CL: Analyze


85. 4. Sitting or holding a child upright for formula feedings helps prevent pooling of formula in the pharyngeal area. When the vacuum in the middle ear opens into the pharyngeal cavity, formula (along with bacteria) is drawn into the middle ear. Cleaning the ear canals does not reduce the incidence of otitis media because the pathogenic bacteria are in the nasopharynx, not the external area of the ears. Continuous low-dose antibiotic therapy is used only in cases of recurrent otitis media, when the child finishes a course of antibiotics but then develops another ear infection a few days later. Although accumulation of cerumen makes it difficult to visualize the tympanic membrane, it does not promote inner ear infections.

 CN: Health promotion and maintenance;
CL: Evaluate

86. 3. Calling a client “contrary” is critical in nature and judgmental on the nurse's part. It is inappropriate for the nurse to make a comment like this at shift report or at any time. The other statements provide important and appropriate information (diagnosis, physician's name, pain relief strategies, and evaluation of ambulation).


 CN: Management of care; CL: Apply

87. 1. The nurse should teach personnel to communicate with clients who are withdrawing from alcohol and street drugs in a calm, matter-of-fact manner, using short sentences and a moderate tone of voice. This approach promotes orientation, reinforces cognitive-perceptual functions, and decreases anxiety. A cheerful tone and humor are inappropriate, possibly leading to misperceptions by the client with cognitive-perceptual impairment. Using general and abstract terms and a loud tone of voice increases anxiety and may lead to misunderstanding. Lengthy explanations delivered with a quiet voice will lead to frustration and increased anxiety.


 CN: Psychosocial adaptation;
CL: Evaluate

88. 3. The best opportunity for a successful pregnancy is when the normal menstrual cycle is created either naturally or through hormonal augmentation. Implantation can occur only when the levels of estrogen and progesterone are at particular levels. For many women, more than one fertilized egg is placed into the uterus. This increases the risk that


more than one embryo will implant and reach maturity. Couples can choose to utilize their own eggs and sperm if they have been determined to be healthy or they can choose to use donor oocytes and sperm. For many women who utilize in vitro fertilization, a career has taken precedence over having a family and these women will need to rebalance a career with the demands of pregnancy and parenting.

 CN: Physiological adaptation;
CL: Evaluate


89. 1, 3, 4. Vitamins B₆, B₁₂, and iron are important in the production of red blood cells. Therefore, the nurse should question the client specifically about food intake that contains these vitamins and minerals. Vitamins K and C have little role in the production of red blood cells.

 CN: Health promotion and maintenance;
CL: Analyze


90. 1. During the emergent phase of burn care, one of the most significant problems is hypovolemic shock. The development of hypovolemic shock can lead to impaired blood flow through the heart and kidneys, resulting in decreased cardiac output and renal ischemia. Efforts are directed toward replacing lost fluids and preventing hypovolemic shock. Preventing infection and controlling pain are important goals, but preventing circulatory collapse is a higher priority. It is too early in the stage of burn injury to promote wound healing.

 CN: Physiological adaptation;
CL: Synthesize

91. 2. A client with multiple sclerosis may have a sense of optimism and euphoria, particularly during remissions. Euphoria is characterized by mood elevation with an exaggerated sense of well-being. Inappropriate laughter, slurring of words, and visual hallucinations are uncharacteristic of euphoria.

 CN: Psychosocial adaptation;
CL: Analyze

92. 1. The “rule of nines” is used to determine the percentage of the client’s body surface area that was burned. Medical treatment, including fluid volume replacement therapy, is based on the percentage of body surface area burned.


 CN: Physiological adaptation;
CL: Analyze

93. 2. The “click” the nurse feels when abducting the femur is made by the head of the femur as it slips into the acetabulum. This is Ortolani’s sign and indicates a dislocated hip. This is not a normal finding for a 2-month-old. The nurse needs to gather additional information by checking for unequal leg lengths and asymmetry of the gluteal and thigh folds. Once the nurse has obtained additional


assessment information, the nurse would notify the physician. Usual medical treatment involves keeping the hip joint in an abducted position through triple diapering or a Pavlik harness. The goal of treatment is to keep the head of the femur centered in the acetabulum. Treatment needs to begin as soon as possible. Usually, the earlier treatment is started, the better the outcome.

 CN: Health promotion and maintenance;
CL: Synthesize


94. 4. Warfarin sodium (Coumadin) interferes with clotting. The nurse should monitor the PT and evaluate for the therapeutic effects of Coumadin. A therapeutic PT is between 1.5 and 2.5 times the control value; the PT should be established by the health care provider. It may also be reported as an International Normalized Ratio, a standardized system that provides a common basis for communicating and interpreting PT results. The PTT is monitored in clients who are receiving heparin therapy. Serum potassium levels and ABG values are not affected by Coumadin.

 CN: Pharmacological and parenteral therapies;
CL: Analyze


95. 4. The lower abdominal pain is most likely caused by bladder spasms. A common cause of bladder spasms after TURP is blood clots obstructing the catheter; therefore, the nurse’s first action should be to assess the patency of the catheter. Auscultating the abdomen for bowel sounds would be appropriate after patency of the catheter has been established. The nurse should assess for bladder spasms before administering an analgesic. A sitz bath would not relieve bladder spasms that are caused by an obstructed catheter.

 CN: Physiological adaptation;
CL: Synthesize


96. 1. The nurse should not automatically discard the partial fill of imipenem-cilastatin (Primaxin) found at the client’s bedside until further investigation is done. The nurse should recognize the cost of medications such as imipenem-cilastatin and consult the pharmacist after identifying information on the partial fill that was found. The nurse should also ascertain whether the client received the last dose of imipenem-cilastatin. If the client did not receive the last dose, the nurse should notify the physician that the client did not receive the dose, receive orders, document, implement the orders, and complete an incident report. The nurse should administer the new partial fill of imipenem-cilastatin so that the client can receive the antibiotic on time.

 CN: Safety and infection control;
CL: Synthesize


97. 2. For a client with moderate anxiety, the nurse should initially lead the client to a less stimulating environment and help him discuss his feelings. Doing so helps the client to gain control over anxiety that could be overwhelming. Telling the client that it would be best to lie down until he is calmer is not appropriate because the client is too anxious to benefit from this intervention. Suggesting that the client try relaxation exercises could be helpful after the nurse takes the client to a less stimulating environment and allows the client to vent and discuss his feelings. Getting some medication to help the client relax is an intervention that the nurse would carry out later after trying to help the client decrease anxiety through ventilation and relaxation exercises.

 CN: Psychosocial adaptation;
CL: Synthesize

98. 1. Clients who are receiving anticoagulant therapy should consult the physician before undergoing any dental work. The dentist should also be aware that the client is taking anticoagulants. A soft toothbrush is desirable for oral hygiene if the client is receiving anticoagulant therapy; it helps prevent the gums from bleeding. Rectal suppositories are contraindicated during anticoagulant therapy because their insertion may cause bleeding. Stool softeners may be used instead to prevent straining, which also may promote bleeding. Green leafy vegetables should not be eaten in excess because of their vitamin K content, which may alter the effectiveness of the anticoagulant therapy.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

99. 3. Increasing the client's fluid intake to 3,000 mL/day, unless contraindicated, is the most appropriate action. Typically, clients who are immobilized by skeletal traction are given stool softeners. Treating constipation with diet, increased fluids, and stool softeners is preferred to the administration of an enema. Placing the client on the bedpan will not encourage a bowel movement. Range-of-motion movements maintain joint mobility but do not stimulate peristalsis.

 CN: Reduction of risk potential;
CL: Synthesize

100. 1, 3, 4, 5. Although about 50% of diarrhea in clients receiving tube feedings is caused by sorbitol-containing medications, the nurse should assess for other possible causes. Diarrhea can occur as a result of bacterial contamination if fresh formula is not used or stored in a refrigerator, or if the feeding apparatus is not changed at least every 24 hours. Lactose intolerance, rapid formula administration, low serum albumin level, and hypertonic solutions


may also cause diarrhea. Hypotonic solutions would not be a likely cause of diarrhea, abdominal distention, or cramping.

 CN: Basic care and comfort;
CL: Synthesize

101. 4. Risk factors for postoperative pulmonary complications include malnourishment, which is indicated by the client's height and weight. Although keeping feelings inside can be problematic, it would not be considered a postoperative risk for pulmonary complications. The absence of dyspnea on exertion is not indicative of postoperative complications. The client's age does not necessarily place her at increased risk.

 CN: Health promotion and maintenance;
CL: Analyze


102. 2. Administering an antiemetic before beginning chemotherapy and then routinely around the clock helps prevent nausea and vomiting. Waiting until the client requests it may be too late because nausea is already present.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


103. 1. Greenish colored amniotic fluid is caused by the passage of meconium, usually secondary to a fetal insult during labor. Meconium passage also may be related to an intact gastrointestinal system of the neonate, especially those neonates who are full term or of postdate gestational age. Amnioinfusion may be used to treat the condition and dilute the fluid. Cloudy amniotic fluid is associated with an infection caused by bacteria or a sexually transmitted disease. Severe yellow-colored fluid is associated with Rh incompatibility or erythroblastosis fetalis.

 CN: Health promotion and maintenance;
CL: Analyze


104. 1. The pH of 7.24 indicates that the client is acidotic. The carbon dioxide level is normal, but the HCO_3^- level is decreased. These findings indicate that the client is in metabolic acidosis.

 CN: Physiological adaptation;
CL: Analyze


105. 3. Black, tarry stools indicate the presence of a slow upper gastrointestinal bleed. The longer the blood is in the system, the darker it becomes as the hemoglobin is broken down and iron is released. Vital sign changes, such as an increased pulse, are not evident with slow gastrointestinal bleeds. Nausea and abdominal cramps can occur but are not definitive signs of gastrointestinal bleeding.

 CN: Physiological adaptation;
CL: Analyze


106. 1. Most adolescents with Osgood-Schlatter disease are able to continue to exercise and use ice afterward. Ibuprofen also may be ordered. Because Osgood-Schlatter disease is self-limited, crutches or physical therapy is usually unnecessary, and the adolescent usually does not need to stop playing sports. Only in severe cases would the adolescent have to stop playing sports.

 CN: Physiological adaptation;
CL: Synthesize

107. 3. Iron supplements will darken the stools. Iron supplements should not be taken on an empty stomach because they can cause gastric irritation. Iron is constipating, and a daily bulk-forming laxative should be started prophylactically. A straw should be used when taking liquid iron to avoid discoloring the teeth.

 CN: Pharmacological and parenteral therapies; CL: Apply


108. 1. A client with generalized anxiety disorder needs to learn cognitive and behavioral strategies to cope with anxiety appropriately. In doing so, the client's anxiety decreases and becomes more manageable. The client may need assertiveness training, reframing, and relaxation exercises to adaptively deal with anxiety.

 CN: Psychosocial adaptation;
CL: Synthesize

109. 4. Deep breathing helps prevent microatelectasis and pneumonitis and also helps force air and fluid out of the pleural space into the chest tubes. It does not decrease blood flow to the lungs or control the rate of air flow. The diaphragm is the major muscle of respiration; deep breathing causes it to descend, thereby increasing the ventilating surface.


 CN: Reduction of risk potential;
CL: Apply

110. 2. When applying an elastic bandage to a leg, start at the distal end and move toward the trunk in order to support venous return. Tension should be kept even and not increased with each turn to prevent circulatory impairment. Overlapping each layer twice when wrapping can also impair circulation. The clips securing the bandage should be placed on the outer aspect of the leg to avoid creating a pressure point on the other leg.


 CN: Reduction of risk potential;
CL: Evaluate

111. 1. Spermicidal agents work by destroying the spermatozoa before they enter the cervix. In addition, some spermicides alter the vaginal pH to a strong acidic environment, which is not conducive


to survival of spermatozoa. Spermicides do not prevent the spermatozoa from entering the uterus, but the diaphragm or condom is a barrier.

 CN: Pharmacological and parenteral therapies; CL: Apply


112. 4. A low dosage of sertraline is helpful in controlling dementia-induced paranoia and hallucinations. Methylphenidate would be indicated for attention deficit hyperactivity disorder. Lorazepam would be ordered if the client were anxious and agitated. Nefazodone would be used if depression were prominent.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

113. 1. Increased fremitus can be present in bacterial pneumonia, indicating the presence of pulmonary consolidation. Additional findings would include crackles, bronchial breath sounds, and dullness on percussion. Bilateral expiratory wheezing and resonance on percussion are not present in bacterial pneumonia. Vesicular breath sounds are normal and would not be an expected finding in bacterial pneumonia.

 CN: Physiological adaptation;
CL: Analyze

114. 3. Acute pancreatitis is very painful; management involves interventions for pain. Although alcohol abuse is often implicated in pancreatitis, drug and alcohol counseling will be an individual consideration. Risk for injury and ineffective airway clearance are not typically associated with acute pancreatitis.


 CN: Basic care and comfort;
CL: Synthesize

115. 1, 2, 5, 6. To treat a low blood glucose level, the nurse should provide the client with approximately 15 g of carbohydrate and monitor the blood glucose level within 15 minutes. The orange juice, milk, bread, and soda would provide approximately 15 g of carbohydrate. Meat or fish, such as tuna, does not contain carbohydrate, although some of it can be converted to carbohydrate if sufficient carbohydrate from other sources is not provided. Processed peanut butter may contain small amounts of carbohydrate, but it is also high in fat and protein. To raise a blood glucose level in a timely manner, peanut butter is not a good option.


 CN: Reduction of risk potential;
CL: Synthesize

116. 3. Increased ICP can cause vomiting, particularly in children whose fontanels are closed. An infant with an open anterior fontanel may have less


vomiting because the cranium can respond, expanding with increased ICP. The best course of action is to wait a few minutes and then refeed the child. Putting the child on NPO status may not be helpful because this is not a gastrointestinal problem. Because this is an expected event, notifying the physician is not necessary. Antiemetics frequently make a client sleepy, making neurologic checks difficult to interpret.

 CN: Physiological adaptation;
CL: Synthesize


117. 1. The air is injected into the long-acting insulin first. Air is then injected into the short-acting insulin and the short-acting insulin is withdrawn. Then the long-acting insulin is withdrawn. It does matter which insulin is drawn up first because the nurse does not want to contaminate the short-acting insulin with the long-acting insulin. It is not necessary to use a high-dose insulin syringe to prepare 28 units of insulin.

 CN: Pharmacological and parenteral therapies; CL: Apply


118. 2. Solids should be introduced at about age 5 to 6 months. Full-term infants use up their prenatal iron stores within 4 to 6 months after birth. Cow's milk contains insufficient iron.

 CN: Health promotion and maintenance;
CL: Apply

119. 3. Diminished breath sounds during an acute asthma attack are a serious sign of airway obstruction, fatigue, and impending respiratory failure. Wheezing, coughing, and the production of sputum indicate the presence of airflow through the lungs and are less ominous symptoms.

 CN: Physiological adaptation;
CL: Analyze


120. 1. Clients should use an electric razor, instead of a straight-edge razor, on any skin areas that are receiving radiation. The skin should be cleaned daily with a mild soap, not harsh antibacterials. Lotion should be removed from the skin before any treatment and then reapplied after the treatment. The radiated skin area needs to be kept clean, dry, and open to air.

 CN: Basic care and comfort;
CL: Synthesize


121. 3. A moderate amount of bloody drainage could indicate active bleeding. The priority action is to apply pressure to the area and call for help. Assessing the airway or pulse or administering oxygen does not address the bleeding.

 CN: Reduction of risk potential;
CL: Synthesize

122. 4. Because valproic acid is associated with thrombocytopenia and hypofibrinogenemia, routine follow-up blood work would consist of monitoring platelet and fibrinogen levels for decreases. A CBC count and serum electrolyte level are not necessary. Aspartate transaminase, not alkaline phosphatase, is routinely monitored to evaluate for hepatic toxicity, a possible but rare effect of valproic acid. Valproic acid has no effect on cholesterol levels.

 CN: Pharmacological and parenteral therapies; CL: Apply


123. 3. Bacterial conjunctivitis is very contagious. Attention should be paid to thorough hand washing, a major means of stopping the transmission of the disease. Closing the day care center for 1 week is not necessary because thorough hand washing will stop the spread of the infection. Keeping the children out for 48 hours is not necessary. A child may return to day care after being treated for 24 hours. Although the parents of each child should be told about the outbreak, doing so will not help to curtail or prevent the spread of the infection.

 CN: Safety and infection control;
CL: Synthesize

124. 3. The client's mobility status is the best indicator of risk for development of a pressure sore. Nutritional and circulatory status are other factors that can contribute to pressure sore development, but immobility, even in the presence of adequate nutrition and circulation, is the leading cause of pressure sores. Disorientation can cause a client to neglect making needed position changes, but the underlying factor will be immobility.


 CN: Reduction of risk potential;
CL: Analyze

125. 1. Ketosis is an adaptation to prolonged fasting or carbohydrate deprivation. The body takes partially broken-down fat fragments and combines them into ketone bodies, which the brain can then use for energy. Hypoglycemia is more likely to occur than hyperglycemia, although glucagon assists in preventing this. Metabolic syndrome refers to syndrome X, which includes an abnormal lipid profile and a tendency to gain weight in the abdomen. Lactic acidosis is a metabolic reaction that occurs when oxygen is reduced or not present.


 CN: Physiological adaptation;
CL: Analyze

126. 1. The nurse should stop and assess the client further. A chair should be available for the client to sit down. Obtaining the client's blood pressure and heart rate are important when exercising. These values can be used to predict when the oxygen demand becomes greater than the oxygen supply. Calling for


help is not necessary for the complaint of midsternal burning. If the physician has ordered nitroglycerin, the nurse can administer it; however, stopping the activity may restore the oxygen balance.

 CN: Physiological adaptation;
CL: Synthesize


127. 2, 3, 4. Vitamin B₆, folate, and vitamin B₁₂ have been shown to reduce homocysteine levels. The effects of vitamins K and D have not been established with regard to homocysteine.

 CN: Health promotion and maintenance;
CL: Synthesize


128. 2. The statement, “If I forget a dose, it’s no big deal, I’ll just take it when I remember it,” indicates a knowledge deficit. The nurse should reinforce that the client should take dexamethasone as prescribed and at the same time each day. The drug has to be tapered off and cannot be stopped abruptly. The physician should be notified when the client is under additional stress (e.g., infection, surgery, illness). The client can have an allergic reaction to inactive ingredients contained in dexamethasone.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

129. 1. A child with moderate dehydration, described as a loss of 50 to 90 mL/kg of body fluid, would have oliguria, gray skin color, increased pulse rate, and poor skin elasticity. A child with severe dehydration, described as a loss of more than 100 mL/kg of body fluid, would have a rapid and thready pulse, very poor skin elasticity, and mottled skin color. A child with mild dehydration, described as a loss of less than 50 mL/kg of body fluid, would have pale skin color, decreased skin elasticity, decreased urine output, and normal or increased pulse rate.


 CN: Physiological adaptation;
CL: Analyze

130. 1. Oropharyngeal candidiasis, or thrush, is the most common infection associated with the early symptomatic stages of HIV infection. Thrush is characterized by whitish yellow patches in the mouth. Various other opportunistic diseases can occur in clients with HIV infection, but they tend to occur later, after the diagnosis of acquired immunodeficiency syndrome has been made. Dyspnea can be indicative of pneumonia, which is caused by a variety of infective organisms. Bloody diarrhea is indicative of cytomegalovirus infection. Hyperpigmented lesions are indicators of Kaposi’s sarcoma.


 CN: Physiological adaptation;
CL: Analyze

131. 2. Postpartum infection is a leading cause of maternal mortality in the United States. Typical treatment for the condition is I.V. antibiotic therapy


with drugs such as clindamycin, gentamicin, or both. Cultures of the lochia will also be obtained. The neonate can continue to breast-feed as long as the mother desires. A switch to bottle-feeding is not necessary. The uterus tends to be firm, with increased cramping to rid the uterus of the infection. The client should be encouraged to remain in Fowler’s position when in bed to allow for drainage of the lochia.

 CN: Physiological adaptation;
CL: Synthesize

132. 1. The mother needs further instruction when she says, “I should position the baby the same way for each feeding.” This can contribute to sore nipples. The position should vary for each feeding to prevent repeated pressure on the same area each time. Grasping the entire areola and nipple will help to decrease nipple soreness. Air drying the breasts and not using a hand pump will help to decrease nipple soreness.

 CN: Health promotion and maintenance;
CL: Evaluate

133. 1. During an acute attack of vertigo, it is best for the client to lie down in a darkened, quiet room and to avoid sudden position changes. A low-sodium diet may be helpful in decreasing the number of attacks, but it is not recommended during the attack. Headaches are not a component of the vertigo attack. Because vertigo is frequently accompanied by nausea and vomiting, the client will not want to eat or drink. Fluids are usually administered parenterally to maintain hydration and administer medications.

 CN: Physiological adaptation;
CL: Synthesize

134. 3. The American Academy of Pediatrics recommends that all neonates should receive only formula or breast milk for the first 4 to 6 months of life. Cereal will not help the neonate sleep through the night and may result in allergies and other digestive disorders.


 CN: Health promotion and maintenance;
CL: Synthesize

135. 2. Once the client has stated that he is allergic to a substance, the nurse would be negligent to ignore the client’s statement and administer the substance. The nurse should check the chart for allergies and call the physician for an alternative antibiotic prescription.


 CN: Management of care; CL: Synthesize

136. 1. Jaundice that persists past the third or fourth day of life and pale, light stools are associated with biliary atresia. Alkaline phosphatase levels will also be elevated. Surgical intervention is necessary


to remove the blockage. Rh isoimmunization and ABO incompatibility are associated with neonatal anemia as the red blood cells are hemolyzed by the antibodies. Esophageal varices are associated with cirrhosis of the liver and large amounts of bleeding when the vessels rupture. The child with esophageal varices will exhibit manifestations of anemia such as pallor, and may experience hemorrhage and shock.

 CN: Physiological adaptation;
CL: Analyze


137. 1. Most parents find it especially difficult to allow a child who was unable to be normally active before corrective heart surgery to lead a normal and active life after surgery. These parents are less likely to be apprehensive about persuading the child of the need for rest, about postoperative complications, or having the child out of school for a month.

 CN: Physiological adaptation;
CL: Synthesize

138. 3. After abdominal surgery, the reason for inserting a NG tube is to decompress the gastrointestinal tract until peristaltic action returns. Compression may be used to control bleeding esophageal varices. Lavage is used to remove substances from the stomach or control bleeding. Gavage is used to provide enteral feedings.

 CN: Physiological adaptation;
CL: Evaluate


139. 3. The most common long-term problem experienced by children with cleft palate repair is speech problems. These children frequently need speech therapy for a period of time. Hearing problems may occur as a result of chronic ear infections and the placement of myringotomy tubes. A poor self-concept may develop in any child. However, if a child with a cleft palate receives adequate parenting and support, this should not occur. Chronic sinus infections are more commonly associated with asthma, not with this defect.

 CN: Physiological adaptation;
CL: Apply

140. 2. Feeding solutions that have not been infused after hanging for 8 hours should be discarded because of the increased risk of bacterial growth. Sitting the client upright during the feeding helps prevent aspiration of the feeding. A gastric residual of 25 mL is considered acceptable. A gastric residual of 100 to 150 mL, or a residual greater than 100% of the previous hour's intake, indicates delayed emptying. The feeding solution should be at room or body temperature.

 CN: Pharmacological and parenteral therapies; CL: Analyze


141. 3. Furosemide is a loop diuretic and inhibits the reabsorption of sodium and chloride from the proximal and distal renal tubules and the loop of Henle. Furosemide promotes sodium diuresis, resulting in a loss of potassium and serious electrolyte imbalances. Furosemide does not affect the BUN level.

 CN: Pharmacological and parenteral therapies; CL: Analyze


142. 3. Suctioning the respiratory tract for prolonged periods depletes the client's oxygen supply and causes hypoxia. It is recommended that each suctioning period not exceed 15 seconds.

 CN: Reduction of risk potential;
CL: Apply


143. 2. The most appropriate action is to encourage the daughter to talk to her mother about the end-of-life issues first to reach a consensus or agreement. This is a family decision. Immediately informing the physician or preparing to remove the client from life support would be premature if the family is not in agreement. Although a copy of the living will should be on the client's chart, it is up to the daughter to show it to her mother.

 CN: Psychosocial adaptation;
CL: Synthesize

144. 2, 3, 4. Contraindications for t-PA or alteplase recombinant therapy include current active internal bleeding, 3 hours or longer since the onset of symptoms of a stroke, and severe hypertension. Age greater than 65 years or having had an alcoholic beverage are not contraindications for the therapy.

 CN: Pharmacological and parenteral therapies; CL: Analyze

145. 1. Extreme muscle weakness is present in both cholinergic crisis and myasthenic crisis. In cholinergic crisis, I.V. edrophonium chloride (Tensilon), a cholinergic agent, does not improve muscle weakness; in myasthenic crisis, it does. Diaphoresis and increased salivation are not present in cholinergic crises.

 CN: Physiological adaptation;
CL: Analyze

146. 3. For a complete breech, the buttocks present, the feet and legs are flexed on the thighs, and the thighs are flexed on the abdomen. For a frank breech, the buttocks present with the hips flexed and the legs extended against the abdomen and chest. This is the most common type of breech presentation. For a compound breech, the buttocks present together with another part, such as a hand. This is a rare occurrence. For an incomplete breech, one or both feet or the knees extend below


the buttocks. This can also be termed a single footling or double footling breech.

 CN: Health promotion and maintenance;
CL: Analyze


147. 1. It is important that the client understand that alcohol should be avoided for at least 1 year after an episode of hepatitis. Sexual intercourse does not need to be avoided, but the client should be instructed to use condoms until the hepatitis B surface antigen measurement is negative. The client will need to restrict activity until liver function test results are normal; this will not occur within 1 to 2 weeks. Jaundice will subside as the client recovers; it is not a permanent condition.

 CN: Reduction of risk potential;
CL: Evaluate


148. 4. The individual who is bulimic is most commonly female and age 15 to 24. She binges and purges to control her weight and to prevent weight gain. Sometimes excessive exercise is also used. Use of regular exercise and calorie counting and occasional use of diet medication to maintain normal weight are not considered dysfunctional in our society.

 CN: Psychosocial adaptation;
CL: Synthesize

149. 1, 4, 5, 6. Diazepam (Valium) is a benzodiazepine that causes symptoms of withdrawal when stopped abruptly. The nurse should assess the client for tremors, agitation, irritability, insomnia, vomiting, sweating, tachycardia, headache, anxiety, and confusion. Euphoria or elevated mood is not a symptom of benzodiazepine withdrawal.


 CN: Pharmacological and parenteral therapies; CL: Analyze

150. 1. Parents are typically quick to notice changes in their infant's physical appearance. The removal of the infant's hair may be upsetting to them if they have not been told why it is being done. Hair may be removed on the scalp at the site of needle insertion for I.V. therapy to provide better visualization and a smooth surface on which to attach tape to secure the needle. Sedatives are not ordinarily prescribed before I.V. fluid administration. In most instances, it is acceptable for parents to visit their infant while the I.V. solution is infusing. Holding the infant is encouraged to provide comfort.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

151. 1. Abdominal pain can be a significant problem in acute pancreatitis. An expected outcome is to decrease or eliminate the pain the client is experiencing. Patterns of bowel elimination and liver

function are not typically affected by pancreatitis. The client should avoid alcohol.

 CN: Physiological adaptation;
CL: Synthesize

152. 3. The most appropriate initial response by the nurse would be to test the child's blood glucose level. The child's symptoms are consistent with hypoglycemia but could also be used by the child to avoid participation in planned activities. Administering milk or fruit juice during a mild reaction may also be appropriate if testing cannot be done. Notifying the physician may be appropriate after the child's glucose level has been obtained and emergency treatment has been initiated if the child is experiencing hypoglycemia. Returning the child to previous activities is not appropriate until either testing or administering treatment has been done.

 CN: Physiological adaptation;
CL: Synthesize

153. 3. Normally, breasts are about the same size. They can vary in size before menstruation due to breast engorgement caused by hormonal changes. It is not necessary for a physician to check this slight change in breast size. The changes in breast size this client described are most likely caused by hormonal changes, not a benign cyst or normal growth and development.

 CN: Health promotion and maintenance;
CL: Synthesize


154. 2. Traditional Chinese medicine describes health as the balance of yin and yang. It describes health as harmony between the mind, body, and soul.

 CN: Health promotion and maintenance;
CL: Apply


155. 2. Before an IVP, the client should be assessed for allergies to iodine. Shellfish is a source of iodine, so people who are allergic to shellfish should not receive an IVP. Asking the client whether he or she has ever had an IVP before can help determine the degree of teaching needed before the procedure, but that is not the most important question. Neither the client's last bowel movement nor urinary incontinence has any relationship to an IVP.

 CN: Reduction of risk potential;
CL: Analyze


156. 3. Progestin alone has no effect on breast milk or breast-feeding once the milk supply is well established. Estrogen suppresses milk output. Testosterone is not given as an oral contraceptive.

 CN: Pharmacological and parenteral therapies; CL: Apply


157. 2. In this situation, the client has indicated that she is not willing to leave the abusive boyfriend because of potential economic concerns and other children in the household. The nurse should explain the cycle of abuse (e.g., tension-building phase, battering incident, and honeymoon phase). The priority intervention is to assist the client to make concrete plans for the safety of herself and her children. The client should identify the safest, quickest routes out of the house and be able to identify where she will go once the cycle of violence escalates. Contacting a social worker at this time is not appropriate because the client is not ready to leave the abusive situation. The nurse can tell the client that these services are available, but it is up to the client to determine whether a referral is necessary. Telling the client that she shouldn't allow anyone to hit her or her children does not assist the client to make plans for her safety and the children's safety should the violence escalate. The client may have a flat affect or feel extreme humiliation from the abuse. The client may also be feeling that the abuse is her fault. When the client is ready to leave the abusive situation and receive continuous counseling, efforts can be taken to increase her self-esteem and prevent additional violence. The client should be made aware of the available services in the community for women who are involved in abusive relationships. The location and phone numbers for available shelters should be provided to the client. Giving her a brochure related to the statistics about violence against women is not helpful and, if found by the abuser, may lead to further violence.

 CN: Psychosocial adaptation;
CL: Synthesize


158. 2. The client who is taking sulfadiazine should be instructed to drink at least eight glasses of water a day to prevent the development of crystalluria. Sulfadiazine should be taken on an empty stomach with a full glass of water. It does not require that the client's urine output be measured and does not affect the color of the urine.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

159. 3. The client is demonstrating loose associations. Therefore, the nurse needs to clarify the meaning of and the connection between ideas. The nurse's statement about Halloween makes the assumption that the client is talking about Halloween from the mention of black cats and black hats. Asking if the client has a black cat is not helpful. The statement about time going faster ignores the client's statement entirely.

 CN: Psychosocial adaptation;
CL: Synthesize


160. 1. MID results from multiple small blood clots in the brain. Therefore, the most critical factor is using anticoagulants to reduce the risk of more infarcts. Administering benzodiazepines such as lorazepam to decrease choreiform movements is associated with Huntington's disease. Although depression is common with MID, managing depression-related symptoms will not slow the progression of MID. Managing symptoms by increasing dopamine availability is appropriate for clients with Parkinson's disease.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


161. 2. Checking the carotid artery pulse in a child during CPR provides information about perfusion of the brain. The brachial pulse is checked in an infant because the infant's short and typically fat neck makes it difficult to palpate the carotid pulse. The femoral and radial arteries might indicate perfusion to the peripheral body sites, but the critical need is for adequate circulation to the brain.

 CN: Physiological adaptation; CL: Apply

162. 2. Nephrotic syndrome is characterized by massive proteinuria caused by increased glomerular membrane permeability. Other symptoms include peripheral edema, hyperlipidemia, and hypoalbuminemia. Because of the edema, clients retain fluid and may gain weight. Hematuria is not a symptom related to nephrotic syndrome.

 CN: Physiological adaptation;
CL: Analyze

163. 2. Because the child has a history of severe hypoxic episodes, having oxygen readily available at the bedside is most important. Should the child experience another hypoxic episode, oxygen could be administered easily and quickly. Although morphine causes peripheral dilation, which causes the blood to remain in the periphery, decreasing system volume, oxygen administration is the priority. Typically a child with tetralogy of Fallot with episodes of hypoxia does not require suctioning.


 CN: Physiological adaptation;
CL: Synthesize

164. 1. Although individuals differ, the most likely attitude of a Mexican-American client is to bear pain stoically, to endure pain as a part of God's will, and to delay seeking treatment.

 CN: Basic care and comfort; CL: Apply

165. 1. When a client voids frequent, small amounts, the nurse should suspect that the client is retaining urine. Palpating for a distended bladder is the first assessment that the nurse should perform to verify this suspicion. Obtaining an order

to catheterize for residual urine may be appropriate as a follow-up activity. Obtaining a urine specimen for culture is not a first priority. The nurse would not encourage an increased fluid intake until further assessment of the situation is completed.

 CN: Physiological adaptation;
CL: Synthesize


166. 3. It is appropriate for the client to be on a low-sodium diet to help decrease fluid retention. Dry skin and pruritus are common in renal failure. Lotions are used to relieve the dry skin, and antihistamines may be used to control itching; corticosteroids are not used. Pain is not a major problem in chronic renal failure, but analgesics that are excreted by the kidneys must be avoided. It is not necessary to measure abdominal girth daily because ascites is not a clinical problem in renal failure.

 CN: Reduction of risk potential;
CL: Synthesize

167. 5, 4, 3, 2, 1. The most frequent cause of respiratory distress in a toddler with no previous illness is foreign body aspiration. After having the clerk call for the rapid response team, the nurse should assess the child for breaths, and then begin abdominal thrusts. Next, the nurse (or rapid response team if present) should assess the effectiveness of the abdominal thrusts, and then start an intravenous infusion. Finally, the nurse can notify the surgeon.

 CN: Reduction of risk potential;
CL: Synthesize

168. 4. The traction weights should be hanging freely to maintain pull. The child needs to be moved up in bed with the weights left untouched to continue countertraction. Then the nurse can determine whether blocks are necessary to maintain the child in the correct position. Raising the weights is inappropriate because doing so interferes with countertraction. The physician does not need to be notified. The nurse can easily correct the problem by moving the child up in bed.


 CN: Physiological adaptation;
CL: Synthesize

169. 1. Children ages 6 to 12 have a slower growth rate than do younger children and adolescents. As a result, their food requirements are comparatively less.

 CN: Health promotion and maintenance;
CL: Apply

170. 4. Asking whether the client is thinking about killing herself is the most direct and therefore the best way to assess suicide risk. Knowing whether the client has recently watched movies on suicide and death, what the client thinks about suicide, or


about previous suicides of family members will not tell the nurse whether the client herself is thinking about committing suicide right now.

 CN: Psychosocial adaptation;
CL: Synthesize


171. 4. Proper nutrition before and during pregnancy helps to ensure that the uterus will be able to support the growth of a healthy placenta. If the placenta never develops properly, the fetus will fail to thrive and the infant may have a low birth weight.

 CN: Health promotion and maintenance;
CL: Analyze


172. 1. Return demonstrations are the best way to evaluate a person's ability to perform a skill. This technique enables the teacher to observe not only the learner's sequencing of steps of the procedure but also the learner's ability to perform the skill.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


173. 3. Ibuprofen (Motrin) should be taken with food or antacids to avoid the development of gastrointestinal distress. Tinnitus is not an adverse effect of ibuprofen; it is a sign of salicylate toxicity. There is no need to increase vitamin B₁₂ intake. The CBC is not typically monitored monthly, although clients should be told to report signs of unusual bleeding because ibuprofen can prolong bleeding time.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


174. 4. The nurse concludes that the staff member needs teaching about depression, specifically the biological basis of major depression, when the staff member states the client has no reason to be depressed because "she really has it all." Major depression, or endogenous depression, is caused by alterations of neurotransmitters, primarily serotonin and norepinephrine. Genetics and hereditary also predispose an individual to develop depression. Therefore, there may not be an external cause or a reason for depression to develop. Depression that occurs from an external cause is known as reactive depression and it could be caused by a loss or a life stress.

 CN: Psychosocial adaptation;
CL: Analyze


175. 4. In asthma, the airways react to certain external and internal stimuli, including allergens, infections, exercise, and emotions. Food allergens commonly associated with asthma include wheat, egg white, dairy products, citrus fruits, corn, and chocolate.

 CN: Physiological adaptation;
CL: Analyze

176. 4. When administering an enema, the nurse should position the client in a left Sims position. Placing the client in this position facilitates the flow of fluid into the rectum and colon. It also allows the client to flex the right leg forward, adequately exposing the rectal area.

 CN: Pharmacological and parenteral therapies; CL: Apply

177. 3. Risk factors for the development of pressure ulcers include poor nutrition, indicated by a decreased serum albumin level. According to the *Guidelines for Pressure Ulcers* published by the Agency for Healthcare Research and Quality, other risk factors include immobility, incontinence, and decreased sensation. A client who does not ambulate often can be repositioned frequently to prevent pressure ulcers. Having an indwelling urinary catheter does not normally increase the risk of developing a pressure ulcer unless pressure from the tubing impinges on urethral or other tissue. An elevated white blood cell count does not place a client at risk for pressure ulcers.

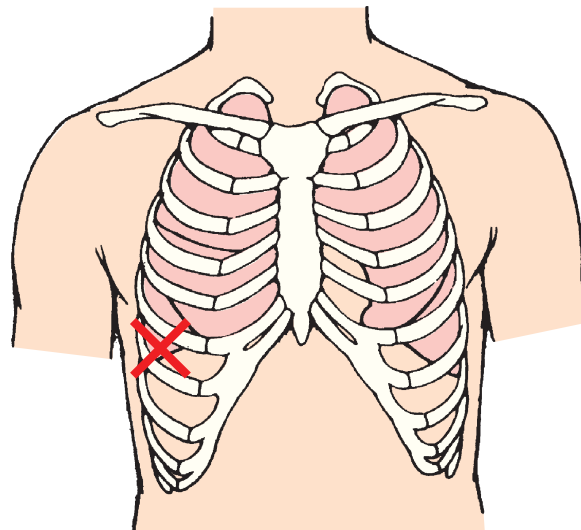
 CN: Reduction of risk potential; CL: Analyze

178. 2. Cerebral hypoxia is commonly associated with dizziness. The greatest risk of injury to a client with dizziness is a fall. Frequent rests and energy conservation measures should be included in the client's plan of care, but safety from falls is the greatest need. Checking the shower water temperature is not critical for this client, who will not be showering because of her fall risk.


 CN: Reduction of risk potential; CL: Synthesize

179. The nurse should auscultate the right lower lobe and listen as the client inhales and exhales. The nurse should be able to hear vesicular breath sounds.

 CN: Physiological adaptation; CL: Apply



180. 1, 2, 5. When an oxygen hood is used, the nurse should be sure the oxygen source is not directed on the infant's face to avoid skin irritation. Mobiles can be used to provide visual stimulation, but they should not be placed inside of the hood where they are a potential choking hazard. It is not necessary to restrain the infant unless there is an indication to do so, and the physician has written the order. There should be as little movement in and out of the hood as possible in order to maintain the warm and humid oxygen levels. The nurse should encourage the parents to visit the child and provide verbal and tactile stimulation.

 CN: Physiological adaptation; CL: Synthesize

COMPREHENSIVE

**TEST
6**

1. A client returns to the recovery room following left supratentorial surgery for treatment of a brain tumor. The nurse should place the client in which position to facilitate venous drainage?

- 1. Lying flat without a pillow with his head turned to the right.
- 2. Lying flat with his head elevated on three pillows.
- 3. Head of the bed elevated to 30 degrees with his head in a neutral position.
- 4. Side-lying on his left side.

2. A 57-year-old Hispanic woman with breast cancer who does not speak English is admitted for a lumpectomy. Her daughter, who speaks English, accompanies her. In order to obtain admission information from the client, what should the nurse do?

- 1. Ask the client's daughter to serve as an interpreter.
- 2. Ask one of the Hispanic nursing assistants to serve as an interpreter.
- 3. Use the limited Spanish learned in high school along with nonverbal communication.
- 4. Obtain a trained medical interpreter.

3. A nurse is caring for a client who has undergone a total laryngectomy for laryngeal cancer. What information is important to include in his discharge teaching? Select all that apply.

- 1. Providing humidity at home.
- 2. Following a bland diet.
- 3. Learning how to suction himself.
- 4. Having communication rehabilitation with a speech pathologist
- 5. Attending a smoking cessation program.

4. The client received electroconvulsive therapy (ECT) an hour ago and tells the nurse that he has a headache. Which response by the nurse is **best**?

- 1. "A headache is common after ECT."
- 2. "I will get some acetaminophen (Tylenol) for you."
- 3. "A nap will help you feel better."
- 4. "Eat your breakfast and then let me know how you feel."

5. The staff nurse is reviewing how to manage the last 2 hours of the night shift on an antepartal unit and has the following orders and tasks to complete prior to 7 a.m. The nurse should complete the tasks at which of the following times?

1. Check documentation, final check of each client.

2. Fetal monitor strip for ½ hour q shift.

3. Magnesium sulfate drawn at 6 a.m.

4. Accucheck and sliding scale insulin due at 7, 11, 4, and hs.

5:30

6:00

6:30

7:00

6. When assessing speech development, which of the following children should the nurse refer for further examination?

- 1. A 4-month-old who laughs out loud.
- 2. A 10-month-old who says "dada" and "mama."
- 3. A 1-year-old who says 3 to 5 words.
- 4. An 18-month-old who only says "no."

7. A family has taken home their newborn and later received a call from the pediatrician that the PKU levels for their newborn daughter are abnormally high. Additional testing confirmed the diagnosis of phenylketonuria. The parents refuse to believe the results as no one else in their family has the disease. The nurse explains that the disease:

- 1. Is carried on recessive genes contributed by each parent.
- 2. Is caused by a recessive gene contributed by either parent.
- 3. Is cured by eliminating dietary protein for this child.
- 4. Will not impact future childbearing for the family.

8. During a clinic visit for a postpartum examination, the mother of a 2-week-old infant tearfully tells the nurse she feels very tired and thinks she is not a good mother to her baby. Which statement by the nurse would be **best**?

- 1. "The hormonal changes your body is experiencing are causing you to feel this way."
- 2. "Most new mothers feel the same way that you do. I hear that a lot from others."
- 3. "You need to have your husband and family help you so that you can get some rest."
- 4. "I'm concerned about what you are experiencing. Tell me more about what you are thinking and feeling."

9. A client is to receive 2 g of metronidazole (Flagyl) orally in a single dose. The medication is available in 500-mg tablets. How many tablets should the nurse administer?

_____ tablets.

10. A college student is asking the nurse about his grandfather, who just received a diagnosis of Huntington's disease. The student wants to know if he will have the disease, too. What should the nurse tell the student? Select all that apply.

- 1. "Huntington's disease affects men more than women."
- 2. "Huntington's disease is an autosomal dominant disease."
- 3. "Huntington's disease does not skip a generation."
- 4. "Huntington's disease is a treatable disease."
- 5. "There is a 75% chance you will have the disease."

11. The nurse notices drops of a liquid on the hallway floor of a health care facility. The nurse should do which of the following **first**?

- 1. Place paper towels over the drops of liquid.
- 2. Don clean gloves and wipe up the drops of liquid.
- 3. Post "wet floor" signs around the area.
- 4. Call the Environmental Services Department.

12. A client is admitted with numbness and tingling of the feet and toes after having an upper respiratory infection and flu for the past 5 days. Within 1 hour of admission, the client states that his legs are numb all the way up to his hips. The nurse should do which of the following **next**? Select all that apply.

- 1. Call his family to come in to visit with him.
- 2. Notify his health care provider of the change.
- 3. Place respiratory resuscitation equipment in the client's room.
- 4. Check for advancing levels of paresthesia.
- 5. Perform ankle pumps to increase circulation and relieve numbness.

13. The nurse is caring for a client with an injury to the thalamus. The nurse should plan to:

- 1. Give higher doses of pain medication.
- 2. Keep patches on the client's eyes to prevent corneal abrasion.
- 3. Monitor the temperature of the bathwater.
- 4. Avoid turning the client.

14. A client who voluntarily admitted herself to the mental health hospital adamantly demands to be discharged immediately. What is the **most** appropriate response by the nurse?

- 1. "We hate to see you go, but that is your right. I'll get the forms for you so you can go."
- 2. "I'm sorry, but your lawyer or family must request such forms when you are hospitalized."
- 3. "I will get the forms, but your psychiatrist will need to see you before you leave."
- 4. "Are you sure we can't convince you to stay here a few days longer? Your insurance is still valid and there are several issues we need to address."

15. A client tells the nurse that he is going to harm his brother-in-law, who called the police on him for threatening to hurt his ex-wife. The nurse should notify which of the following persons? Select all that apply.

- 1. Agency administrators.
- 2. Ex-wife.
- 3. Police.
- 4. Intended victim.
- 5. Social service department.

16. The nurse is planning care for a client who has sustained a spinal cord injury. The nurse should assess the client for:

- 1. Anesthesia below the level of the injury.
- 2. Tingling in the fingers.
- 3. Pain below the site of the injury.
- 4. Loss of position and vibratory sense.

17. A client who is paraplegic cannot feel her lower extremities and has been positioned on her side. The nurse should inspect which of the following areas that is a potential pressure point when the client is in this position?

- 1. Sacrum.
- 2. Occiput.
- 3. Ankles.
- 4. Heel.

18. Which of the following is appropriate when developing a plan of care for promoting the development of a preschooler? Select all that apply.

- 1. Providing anticipatory guidance for parents.
- 2. Helping the parents understand their child's behavior.
- 3. Identifying deviations from normal growth and development patterns.
- 4. Determining the child's future development.
- 5. Sending the child to a day care center.

19. A neonate is to receive an I.V. infusion of normal saline solution at 3 mL/hour. The nurse is setting the alarms on an I.V. infusion pump. How should the nurse set the alarms?

- 1. At 5% above and 5% below the keep-vein-open rate.
- 2. Within a 15% range of the keep-vein-open rate
- 3. To sound when the infusion is infiltrating.
- 4. At the exact drip rate as prescribed.

20. A client is admitted to the inpatient unit and is exhibiting pressured speech, a labile affect, euphoria, and hyperactivity. The client states, "I am the Savior of the city." The family states that the client has hardly slept or eaten for days. Which of the following client needs is a **priority** in the nurse's plan of care?

- 1. Physical.
- 2. Social.
- 3. Spiritual.
- 4. Cultural.

21. A neonate is receiving an I.V. infusion of dextrose 10% in water administered by an infusion pump. The nurse should verify the alarm settings on the infusion pump at which times? Select all that apply.

- 1. When the infusion is started.
- 2. At the beginning of each shift.
- 3. When the neonate returns from X-ray.
- 4. When the neonate moves in the crib.
- 5. After the parents have visited.

22. The nurse is caring for a critically ill client with the client's mother and spouse in the room. The spouse begins to shout derogatory comments to the mother, blaming her for her spouse's critical state. What should the nurse do?

- 1. Try to calm both the mother and spouse by speaking in a soft voice.
- 2. Step between the mother and spouse stating emphatically, "Stop!"
- 3. Call the hospital Security Department.
- 4. Report the details immediately to the supervisor.

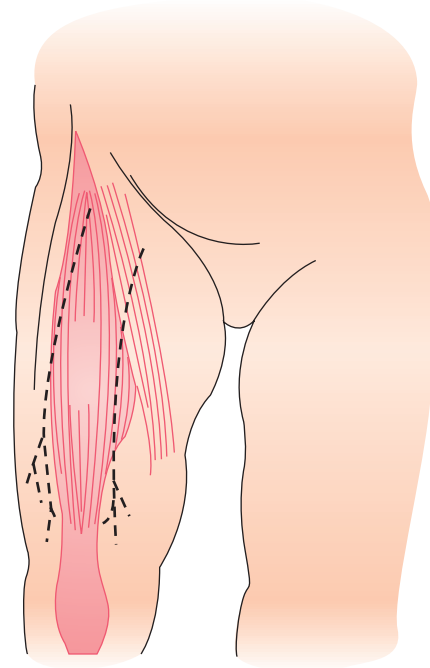
23. The nurse is planning care for a neonate to prevent neonatal heat loss immediately after delivery. To conserve heat and help the infant maintain a stable temperature, the nurse should:

- 1. Nestle the neonate against the crib wall.
- 2. Place a hat on the neonate's head and wrap the neonate in a blanket.
- 3. Bathe the neonate with warm water.
- 4. Position the neonate lying in an open crib with a diaper on.

24. The nurse observes that the client's right eye does not close completely. Based on this finding, which of the following nursing interventions would be **most** appropriate?

- 1. Making sure the client wears her eyeglasses at all times.
- 2. Placing an eye patch over her right eye.
- 3. Instilling artificial tears once every shift.
- 4. Cleaning the eye with a clean washcloth every shift.

25. The nurse is administering an intramuscular injection to an infant. Indicate the appropriate site for this injection.



26. A 14-year-old with rheumatic fever who is on bed rest is receiving an I.V. infusion of dextrose 5% in water administered by an infusion pump. The nurse should verify the alarm settings on the infusion pump at which of the following times? Select all that apply.

- 1. When the infusion is started.
- 2. At the beginning of each shift.
- 3. When the child returns from X-ray.
- 4. When the child moves in the bed.
- 5. When the child is sleeping.

27. A potential concern when caring for an older adult who has diminished hearing and vision is the client's:

- 1. Feelings of disorientation.
- 2. Cognitive impairment.
- 3. Sensory overload.
- 4. Social isolation.

28. Which of the following children should be referred for further assessment regarding language development?

- 1. A 2-year-old who has a vocabulary of 300 words and can combine two or three words in a phrase.
- 2. A 3-year-old who has a vocabulary of 900 words and can make a complete sentence of three or four words.
- 3. A 2-year-old who has a vocabulary of 100 words and can point to objects.
- 4. A 1-year-old who has a vocabulary of 8 words and can say "mommy" and "daddy" with specific reference to the correct person.

29. A nurse is taking a medication history on a client with multiple sclerosis before administering an initial dose of baclofen (Lioresal). What should the nurse check **before** administering the drug?

Select all that apply.

- 1. Presence of muscle weakness.
- 2. History of muscle spasms.
- 3. Serum creatinine level.
- 4. Serum potassium level.
- 5. Blood glucose.

30. A client has been taking carbamazepine (Tegretol) for 2 years. The nurse should assess the client for which of the following? Select all that apply.

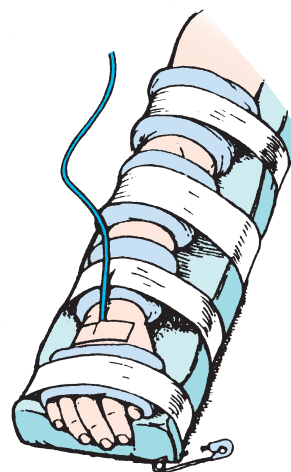
- 1. Bruising.
- 2. Sore throat.
- 3. Urine retention.
- 4. Light-colored stool.
- 5. Hydration status.

31. A 12-year-old client says, "Give me my pajamas. I'm not putting your silly gown on." An appropriate response by the nurse should be:

- 1. "I know they're funny but everyone here wears them."
- 2. "You don't mean that, now. A big guy like you knows how hospitals are."
- 3. "You're upset because you feel awkward and embarrassed in these gowns."
- 4. "You're upset because you think we're unreasonable."

32. A nursing assistant is taking care of a child in the arm restraint shown below. To provide care for this child, what should the assistant do?

- 1. Unpin the restraint and perform range-of-motion exercises.
- 2. Unwrap the restraint and bathe the arm using warm water.
- 3. Leave the restraint in its current position.
- 4. Remove one tape at a time while bathing the child's arm.



33. Which of the following are reasons for the nurse to encourage women to have a "Pap test" (Papanicolaou smear)? Select all that apply.

- 1. To detect precancerous and cancerous cells of the uterus.
- 2. To assess the effects of sex hormonal replacement.
- 3. To identify viral, fungal, and parasitic conditions.
- 4. To evaluate the response to chemotherapy or radiation therapy to the cervix.
- 5. To detect a diminished blood flow to the perineal mucous membrane.

34. The nurse is administering prednisone to a child with nephrosis. To assure that the nurse has identified the child correctly, the nurse should do which of the following. Select all that apply.

- 1. Ask another nurse to confirm that this is the correct dose and correct client for whom the prednisone has been prescribed.
- 2. Check the child's identification band against the medical record number.
- 3. Verify the date of birth from the medical record with the date of birth on the client's identification band.
- 4. Compare the room number on the bed with the number on the client's identification band.
- 5. Ask the client to state his first name.

35. The nurse is administering propranolol (Inderal) to a client for control of migraine headaches. The client's pulse rate is 56 bpm. What should the nurse do **next**?

- 1. Contact the physician immediately.
- 2. Assess blood pressure.
- 3. Administer oxygen.
- 4. Ask for a relative to contact.

36. When a child is able to grasp the idea that a ball continues to exist even though his parent placed the ball under a hat, the child is in which of the following stages in the development of logical thinking, according to Piaget?

- 1. Sensorimotor.
- 2. Preoperational.
- 3. Concrete operations.
- 4. Formal operations.

37. A nurse discusses with parents the procedures that will be performed on their neonate immediately after delivery. The nurse determines that the instructions have been understood when the client states that what will be done to the neonate **first**?

- 1. The neonate will be suctioned.
- 2. The neonate will be dried and stimulated to cry.
- 3. The neonate will be given oxygen.
- 4. The neonate's umbilical cord will be cut.

38. An infusion of lidocaine hydrochloride (Xylocaine) is running at 30 mL/hour. The dilution is 1,000 mg/250 mL. What dosage is the client receiving per minute?

_____ mg/minute.

39. A nurse is instructing a client about the use of nitroglycerin patches. The nurse should instruct the client to:

- 1. Remove the patch every night.
- 2. Use the patch only when chest pain occurs.
- 3. Change the site of the patch every day.
- 4. Apply the patch only on alternate days.

40. The nursing staff has safely and successfully secluded and restrained a client with acute mania who threatened the nurse and threw a chair against the wall in the community room. Which statement by the nurse is **most** helpful to the client at this time?

- 1. "Threatening others and throwing furniture is not allowed."
- 2. "You have been restrained until you can manage your behavior."
- 3. "Since you have been here before, you know what the rules are."
- 4. "We are only doing this for your own good, so calm down."

41. A client is taking 600 mg of valproic acid (Depakene) twice daily. The nurse should assess the client for which of the following? Select all that apply.

- 1. Tremors.
- 2. Hair loss.
- 3. Gastrointestinal upset.
- 4. Anorexia.
- 5. Weight gain

42. A client has a cerclage placed at 16 weeks' gestation. She has had no contractions and her cervix is dilated 2 cm. The nurse is preparing the client for discharge. Which statement by the client should indicate to the nurse that the client needs further instruction?

- 1. "I will need more frequent prenatal visits."
- 2. "I should call if I am leaking fluid or have bleeding or contractions."
- 3. "I can have sex again in about 2 weeks."
- 4. "I can have nothing in my vagina until I am at term."

43. Which of the following conditions is a potential consequence of a prolonged QT interval?

- 1. Serious electrolyte imbalance.
- 2. Predisposition to torsades de pointes.
- 3. Predisposition to atrial fibrillation.
- 4. Development of orthostatic hypotension.

44. A mother calls the clinic after her 4-year-old choked on a peanut. The mother reports that she performed abdominal thrusts and the child is breathing normally now. The nurse should tell the mother to:

- 1. Bring the child to the emergency department to check for airway obstruction.
- 2. Test the child's urine for blood from internal bleeding.
- 3. Call the physician if the child begins to sweat and feels dizzy.
- 4. Observe the child for difficulty breathing because the abdominal thrusts may have caused a pneumothorax.

45. A client is taking nonsteroidal anti-inflammatory drugs (NSAIDs) to manage pain from rheumatoid arthritis. What instruction should the nurse give the client about NSAIDs?

- 1. Take the prescribed medication with food and fluids.
- 2. Gradually decrease the medication dosage.
- 3. Rinse the mouth with water after taking NSAIDs.
- 4. Avoid driving and using machinery while taking NSAIDs.

46. The nurse is assessing a neonate at 5 minutes after birth. The nurse records the Apgar score based on the findings in the chart below.

Flow Sheets	
Apgar at 5 Minutes After Birth	
Heart rate	100 bpm
Respirations	Irregular
Color	Pink
Muscle tone	Moving all four extremities
Reflexes	Cough

The nurse compares these findings to the Apgar score obtained at birth, as determined by the findings in the chart below.

Flow Sheets	
Apgar at Birth	
Heart rate	120 bpm
Respirations	Slow
Color	Blue extremities
Muscle tone	Flexion of extremities
Reflexes	Grimace

What should the nurse do **next**?

- 1. Notify the neonatologist on call.
- 2. Continue to assess the neonate.
- 3. Apply an oxygen mask.
- 4. Rub the neonate's extremities.

47. Communicating with parents and children about health care has become increasingly significant because:

- 1. Consumers of health care cannot keep up with rapid advances in science.
- 2. The influence of the media and specialization have increased the complexity of managing health.
- 3. Nurse educators have recognized the value of communication.
- 4. Clients are more demanding that their rights be respected.

48. The **most** appropriate toys to give to a 5-month-old infant are:

- 1. Plastic toy cars.
- 2. Wooden puzzles.
- 3. Stuffed animals.
- 4. Soft, washable toys.

49. The nurse is beginning the shift and is assessing the oxygen exchange on a neonate. The nurse reviews the chart for pulse oximetry reading for the last 8 hours.

Flow Sheets					
Pulse Oximetry					
Time	7 am	9 am	11 am	1 pm	3 pm
Reading	95%	90%	90%	85%	80%

The pulse oximetry reading at 3:30 p.m. is 75%.

What should the nurse do **first**?

- 1. Administer oxygen via mask.
- 2. Swaddle the neonate in heated blankets.
- 3. Reassess the oximetry reading in 30 minutes.
- 4. Draw blood gases for oxygen and carbon dioxide levels.

50. The nurse reviews the client's laboratory report to determine the client's blood level of valproic acid (Depakene), which is 35 mcg/mL. Based on this report, what should the nurse do **first**?

- 1. Withhold the next dose of valproic acid.
- 2. Notify the physician.
- 3. Give the next dose as ordered.
- 4. Take the client's vital signs.

51. After 2 days on a psychiatric unit, a client is still isolating himself in his room, except for meals. The client says he is uncomfortable around crowds of people. Which nursing intervention is the **most** appropriate initially?

- 1. Play a game of checkers with the client in his room.
- 2. Ask the client to attend a group session with the nurse.
- 3. Invite the client to go for a walk with the nurse and one other client.
- 4. Talk with the client in a corner of the crafts room.

52. A nurse is caring for a woman who delivered a term neonate at 6 a.m. At 4 p.m., the woman has a distended bladder and is reporting pain of 5 on a scale of 1 to 10. The nurse reviews the client's output record.

Intake and Output				
Output Record				
Time	8 am	10 am	11 am	4 pm
	30 mL	50 mL	30 mL	60 mL

What should the nurse do **first**?

- 1. Apply a warm, moist towel over the bladder.
- 2. Ask the woman to sit on the toilet while the nurse runs water from the faucet.
- 3. Administer Tylenol with codeine.
- 4. Use an in-and-out catheter to empty the bladder.

53. The father of a 3-week-old infant who has developed sepsis says that he feels guilty because he did not realize his infant was sick. Which of the following responses by the nurse would be **most** appropriate?

- 1. "You should have realized something was wrong; he is your son."
- 2. "Did you read the booklet on newborns that was sent home with you from the hospital?"
- 3. "What you are feeling is normal; next time, you will know what to look for."
- 4. "Babies can get sick quickly, and parents do not always realize it."

54. A mother brings a 15-month-old child to the well-baby clinic. She states the child has been taking approximately 18 to 20 oz of whole milk per day from a bottle with meals and at bedtime. The nurse should suggest that she begin weaning the child from the bottle to avoid risking:

- 1. Malnutrition.
- 2. Anemia.
- 3. Dental caries.
- 4. Malocclusion.

55. The nurse is preparing to administer furosemide (Lasix) to a 3-year-old with a heart defect. The nurse verifies the child's identity by checking the arm band and:

- 1. Asking the child to state her name.
- 2. Checking the room number.
- 3. Asking the child to tell her birth date.
- 4. Asking the parent the child's name.

56. Diuretic therapy with torsemide (Demadex) is started for a client with heart failure. Two days after the drug therapy is started, the nurse evaluates the torsemide as effective when the client says she has experienced which of the following outcomes?

- 1. She has an improved appetite and is eating better.
- 2. She weighs 6 lb less than she did 2 days ago.
- 3. She is less thirsty than she was before the drug therapy.
- 4. She has clearer urine since starting torsemide.

57. Which of the following techniques is correct for the nurse to use when inserting a rectal suppository for an adult client?

- 1. Insert the suppository while the client bears down.
- 2. Place the client in a supine position.
- 3. Position the suppository along the rectal wall.
- 4. Insert the suppository 2 inches into the rectum.

58. The nurse is preparing to suction a tracheostomy for a client with methicillin resistant staphylococcus aureus (MRSA) (see figure). The nurse should:

- 1. Wear a powered air purifying respirator (PAPR) face shield.
- 2. Use goggles that include the hairline.
- 3. Change to a surgical mask.
- 4. Proceed to suction the client's tracheostomy.



59. A young woman is brought from the emergency department (ED) to the psychiatric unit. ED staff report that she is not answering questions and has been sitting in the same position in the wheelchair for 45 minutes. When her arm was extended to draw blood, she did not move her arm back to a natural position. The client's brother says he found her this way yesterday and couldn't get her to move on her own. Which nursing interventions have a **high** priority in this case? Select all that apply.

- 1. Ask her to describe her stressors.
- 2. Monitor her body positions to prevent injury.
- 3. Offer her nutritional shakes every 3 hours.
- 4. Encourage her to talk about her feelings.
- 5. Assist her to the bathroom every 2 hours.
- 6. Protect her from intrusions by other clients.

60. A client who had a total hip placement at 9 a.m. is receiving an autologous blood transfusion that was started at 11 a.m. At the change of shift (3 p.m.), the day nurse reports that there is 50 mL of the unit of blood remaining to be infused. Which of the following is a **priority** action for the evening nurse?

- 1. Keep the blood transfusing at the same rate.
- 2. Increase the rate so it will infuse by 4 p.m.
- 3. Discontinue the blood transfusion at the beginning of the shift.
- 4. Maintain the current rate and discontinue the blood transfusion at 5 p.m.

61. A client is admitted with fatigue, shortness of breath, pale skin, and dried, cracked lips, tongue, and mouth. Her hemoglobin is 9 g/dL and red blood cell count is 3.5 million cells/mm³. Which of the following foods should the nurse teach this client to include in her diet?

- 1. Beef, beets, and cabbage.
- 2. Lamb, applesauce, and mint jelly.
- 3. Chicken, dumplings, and biscuits.
- 4. Fish, wine, and apples.

62. When assessing a neonate 1 hour after birth, the nurse observes that the neonate exhibits slight cyanosis when quiet but becomes pink when crying. The nurse is unable to pass a catheter through the left nostril. The nurse notifies the pediatrician because the neonate most likely is exhibiting signs and symptoms of which of the following?

- 1. Esophageal reflux disorder.
- 2. Unilateral choanal atresia.
- 3. Respiratory distress syndrome.
- 4. Tracheoesophageal fistula.

63. When developing a teaching plan for parents of toddlers about poisonous substances, the nurse should emphasize which of the following safety points? Select all that apply.

- 1. Toddlers should be adequately supervised at all times.
- 2. All poisonous substances should be kept out of the reach of children and stored in a locked cabinet if necessary.
- 3. The difference between pediatric and adult dosages of medicines is significant and adult dosages given to children can have serious, harmful effects.
- 4. Syrup of ipecac should be administered following all ingestions of poisonous substances.
- 5. Following any poisoning, the parents should call the Poison Control Center for instructions for appropriate treatment.

64. A client on a psychiatric care unit approaches the nurse and complains of muscle spasms in his neck, stiffness in other muscles, and that his eyes are rolling upward. The client had two p.r.n. doses of haloperidol (Haldol) in the last 6 hours. Of the drugs that have been ordered for the client as needed (see chart), the nurse should administer:

Prescriptions

Lorazepam (Ativan) 1 mg I.M.
Amantadine (Symmetrel) 100 mg P.O.
Diphenhydramine (Benadryl) 25 mg P.O.
Benztrapine (Cogentin) 0.5 mg I.M

- 1. Lorazepam (Ativan).
- 2. Amantadine (Symmetrel).
- 3. Diphenhydramine (Benadryl).
- 4. Benztrapine (Cogentin).

65. After delivery of a male neonate at 38 weeks' gestation, the nurse dries the neonate and places him under the radiant warmer. The nurse performs this action based on the understanding that one neonatal response to cold stress involves which of the following?

- 1. Metabolism of brown adipose tissue.
- 2. Decreased utilization of glycogen stores.
- 3. Decreased utilization of calorie stores.
- 4. Increased shivering to keep warm.

66. Twenty-four hours after an appendectomy, a 16-year-old adolescent of Asian ethnicity states that he has no pain but is frowning and has his legs drawn to the fetal position. The nurse should:

- 1. Administer pain medication.
- 2. Ask the adolescent what is troubling him.
- 3. Discuss the adolescent's behavior with the parents.
- 4. Offer a distracting activity such as a videos game.

67. When developing the teaching plan for a primiparous client who is bottle-feeding her term neonate for the first feeding, which of the following instructions should the nurse include?

- 1. Fill the entire nipple of the bottle with formula.
- 2. All term babies have well-developed sucking skills.
- 3. Bubble the baby after 2 oz of formula have been taken.
- 4. Propping of the bottle results in too much air being taken in by the baby.

68. A client complains of back pain 10 minutes after a unit of packed red blood cells (RBCs) was started. The client's pulse, blood pressure, and respirations are stable, and similar to vital signs obtained before infusing the RBCs. What should the nurse do? Select all that apply.

- 1. Turn off the infusion of the packed RBCs.
- 2. Flush the Y-tubing with normal saline to clear the line.
- 3. Insert an indwelling urinary catheter.
- 4. Prepare for cardiopulmonary resuscitation.
- 5. Obtain a urine specimen to send to the laboratory.

69. A primiparous client at 4 hours after a vaginal delivery and manual removal of the placenta voids for the first time. The nurse palpates the fundus, noting it to be 1 cm above the umbilicus, slightly firm, and deviated to the left side, and notes a moderate amount of lochia rubra. The nurse notifies the physician based on the interpretation that the assessment indicates which of the following?

- 1. Perineal lacerations.
- 2. Retained placental fragments.
- 3. Cervical lacerations.
- 4. Urine retention.

70. While performing a gestational age assessment for a newly delivered male neonate who was delivered vaginally at 37 weeks' gestation, the nurse should assess the neonate for:

- 1. An anterior transverse crease on the soles.
- 2. Extensive rugae on the scrotum.
- 3. Some cartilage in the ear lobes.
- 4. Coarse and silky scalp hair.

71. Two family members are visiting their father who is experiencing acute delirium. They are upset that their father is so disoriented. "He knows who we are, but that's about it. We don't know what to say to him." What should the nurse tell the family? Select all that apply.

- 1. "Answer his questions simply, honestly, slowly, and clearly."
- 2. "Correct him when he is hearing and seeing things that are not there."
- 3. "Occasionally remind him of the time, day, and place when he doesn't remember."
- 4. "Include him in your conversation, instead of talking about him while he is present."
- 5. "Raise your voice a bit so you are sure he hears you."

72. A 26-year-old male client is being admitted for treatment of delirium due to acute alcohol intoxication. The client is restless, does not want to stay seated, and has a staggering gait. What should the nurse do **first**?

- 1. Place the client in a chair with a waist restraint.
- 2. Provide one-to-one supervision of the client until detoxification treatment can begin.
- 3. Ask the client to sit in a chair next to the nurses' station.
- 4. Decrease stimuli by putting the client in bed with his room door closed.

73. The nurse is monitoring a client receiving a blood transfusion when the client develops a cough with shortness of breath. The client also complains of a headache and a racing heart. What should the nurse do **first**?

- 1. Slow the infusion rate.
- 2. Replace the blood with saline.
- 3. Administer an antihistamine.
- 4. Place the client flat with the feet elevated.

74. A nurse is obtaining an ankle-brachial index for a client with arteriosclerosis. Identify the correct order for obtaining the ankle-brachial index.

1. Place a Doppler probe at a 45-degree angle to the correct pulse (dorsalis pedis or posterior tibial).

2. Place the client in the supine position.

3. Record the highest systolic blood pressure readings in both arms.

4. Record the ankle systolic blood pressure reading when the Doppler sound returns.

75. A nurse is analyzing a client's intake and output. The client has a temperature of 102° F (38.9° C) and is receiving I.V. fluid therapy because of his nothing-by-mouth status due to acute pancreatitis. Before planning nursing actions, the nurse should first consider which of the following ?

- 1. The client's body mass index.
- 2. Insensible fluid loss through the lungs and skin.
- 3. When the client last ate.
- 4. The number of bags of I.V. fluid for the client.

76. Two toddlers are arguing over a toy in the playroom. The nurse should say to the children:

- 1. "If you can't play together, I'll have to put you back in your rooms."
- 2. "Give the toy to me. Now neither of you will have it."
- 3. "Let me see if I can get both of you a similar toy."
- 4. "Let one of you play with it for awhile, then give it to the other."

77. A 9-month-old infant whose parents have emigrated from Mexico presents in the clinic with severe dehydration from vomiting. The infant was seen in the clinic just 3 days ago for a well-child visit, but now the family seems very distrustful of the health care team. The nurse should ask the parents:

- 1. "Have you been speaking with a healer?"
- 2. "Did anything concern you about your last visit?"
- 3. "Has immigration been causing you problems?"
- 4. "Are you afraid your baby will be taken from you?"

78. A 4-year-old child continues to come to the nurses' station after being told children are not allowed there. What behavior is the child exhibiting?

- 1. Attention-seeking behavior.
- 2. Aggressive behavior.
- 3. Resistive behavior.
- 4. Exaggerated stress behavior.

79. A 5-month-old infant is brought to the emergency department with vomiting and diarrhea, which the mother states started 3 days ago. The nurse should conduct a focused assessment for which of the following? Select all that apply.

- 1. Decreased or absent tearing.
- 2. Dry mucous membranes.
- 3. Sunken fontanel.
- 4. Clear, pale yellow urine.
- 5. Bounding pulse.

80. A neonate of a primiparous client delivered at 36 weeks' gestation in a small, rural hospital is to be transferred by ambulance to a level III nursery. To prepare the parents for the transfer, which of the following should the nurse include in the plan of care?

- 1. Instruct the parents that the neonate is in critical condition.
- 2. Obtain the mother's consent for the neonate's transfer.
- 3. Allow the parents to touch the neonate before transfer.
- 4. Ask the father if he desires to ride in the ambulance during the transfer.

81. A multiparous client delivers a neonate at 24 weeks' gestation. After 12 hours, the neonate's condition deteriorates, and death appears likely within the next few minutes. The parents are Roman Catholic, and they request that the neonate be baptized. Which of the following actions would be **most** appropriate?

- 1. Contact the hospital chaplain to perform the baptism.
- 2. Alert the hospital's director that a neonatal death is imminent.
- 3. Find a health care provider who is Roman Catholic to perform the baptism.
- 4. Baptize the neonate, regardless of the nurse's own religious beliefs.

82. A client has bursitis in the subacromial bursa. A nurse determines that the client understands teaching when he makes which of the following statements?

- 1. "I will apply moist heat to my shoulder for 20 minutes three times each day."
- 2. "I will lift 30-pound weights at least three times each day."
- 3. "I will apply dry ice to my shoulder for 20 minutes three times each day."
- 4. "I will perform 360-degree circles with my arms extended at least three times daily."

83. A client has just undergone a lumbar puncture. Which finding should the nurse immediately report to the physician?

- 1. The client's oral intake was 1,200 mL in the past 8 hours.
- 2. The client required analgesia for headache.
- 3. A moderate amount of serous fluid was noted on the lumbar dressing.
- 4. The client is concerned about the test results.

84. A hospice nurse is caring for a client with breast cancer and brain metastasis. The nurse is reviewing the lab report below. According to the information in the chart, what should the nurse do **next**?

Laboratory Results

Test	Result
Potassium	4.0 mEq/L
Sodium	142 mEq/L
Chloride	100 mEq/L
Calcium	12.4 mg/dL

- 1. Document these results on the medical record.
- 2. Report the elevated potassium level immediately.
- 3. Report the elevated calcium level immediately.
- 4. Refrain from reporting the results because the client is in hospice care.

85. The nurse on the postpartum unit has delegated the care of a multiparous client and her term neonate at 4 hours postpartum to the licensed practical nurse (LPN). Which of the following findings should the LPN report to the nurse immediately?

- 1. Neonatal regurgitation of 1 tablespoon after a feeding.
- 2. Maternal pulse rate of 100 bpm at rest.
- 3. Neonatal heart rate of 140 bpm while at rest.
- 4. Increased maternal lochia rubra with initial ambulation.

86. A child with a cardiac defect assumes a squatting position. The nurse should determine that the position is effective for the child by noting:

- 1. Less energy required to play with toys on the floor
- 2. Less dyspnea.
- 3. Relief of abdominal pressure.
- 4. Improved muscle tone.

87. A client was brought to the emergency department following a motor vehicle accident, and has phrenic nerve involvement. The nurse should assess the client for:

- 1. Alteration in level of consciousness.
- 2. Altered cardiac functioning.
- 3. Ineffective breathing pattern.
- 4. Alteration in urinary elimination.

88. A primigravid client is seen for her first visit in the antenatal clinic and tells the nurse that her brother was born with cystic fibrosis (CF). When teaching the client about this disorder, the nurse should include which of the following? Select all that apply.

- 1. Inheritance is linked to race/culture.
- 2. To inherit CF, each parent must carry a recessive trait for the disease.
- 3. If both parents carry the trait, each offspring has a 25% chance of inheriting the disease.
- 4. Fetal testing can occur by checking the shape of the red blood cells.
- 5. Chorionic villi sampling (CVS) can identify prenatally if their child carries the trait or has the disease.

89. A client with a peritonsillar abscess has been hospitalized. Upon assessment, the nurse determines the following: a temperature of 103° F (39.4° C), body chills, and leukocytosis. The client begins to complain of difficulty breathing. In what order should the nurse perform the following actions?

1. Call the physician.

2. Open the airway.

3. Start an I.V. access site.

4. Explain the situation to the family.

90. The nurse is teaching a client who has deep vein thrombosis from limited mobility that caused a pulmonary embolus, which has resolved. Which of the following instructions should nurse give to this client?

- 1. "Report such signs as leg swelling, discomfort, redness, or warmth."
- 2. "Sit with your legs lower than the rest of your body."
- 3. "Walk at least every other day."
- 4. "Limit your fluids to 1 liter each day."

91. A multiparous client and her neonate, who has been cared for in the intensive care nursery for the past 3 days because of being small for gestational age, are to be discharged. Before their release, the mother tells the nurse, "I've been living in my car for the past 2 weeks." Which of the following should the nurse do **next**?

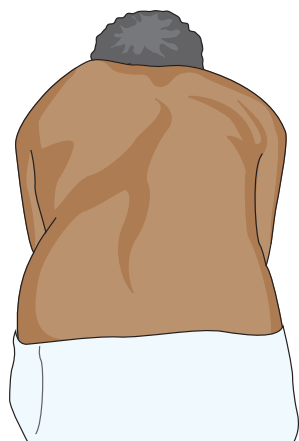
- 1. Notify the director of the birthing unit.
- 2. Contact the hospital's social worker.
- 3. Contact the client's physician.
- 4. Notify the client's family members.

92. A nurse is assessing a client who is having her 14th laser surgery for removal of a birthmark from her left cheek. The nurse should ask this client about which food allergy associated with a surgery risk given the circumstance of multiple surgeries?

- 1. Canned peas.
- 2. Frozen carrots.
- 3. Tomatoes.
- 4. Organ meats.

93. The nurse is assessing a teenage girl. According to the figure below, the nurse should note that the girl has:

- 1. Kyphosis.
- 2. Arthritis.
- 3. Developmental dysplasia of the hip.
- 4. Scoliosis.



94. A client in surgery has an endotracheal tube (ET) in place. The nurse should call a time-out if which of the following requirements is not in place? Select all that apply.

- 1. An identification band.
- 2. Postoperative pain medication.
- 3. An I.V. line.
- 4. Oxygen administration.
- 5. An anesthesiologist.

95. A multiparous client at 16 weeks' gestation is diagnosed as having a fetus with probable anencephaly. The client is a devout Baptist and has decided to continue the pregnancy and donate the neonatal organs after the death of the neonate. Which of the following actions by the nurse would be **most** appropriate?

- 1. Explore his or her own feelings about the issues of anencephaly and organ donation.
- 2. Contact the client's minister to discuss the client's options related to the pregnancy.
- 3. Advise the client that the prolonged neonatal death will be very painful for her.
- 4. Ask the client if she has discussed this with her family.

96. A 3-month-old infant is being discharged on digoxin (Lanoxin). The nurse should instruct the parents to report which of the following? Select all that apply.

- 1. Signs of constipation or painful straining.
- 2. Decrease in the amount of infant formula taken or a refusal to take it.
- 3. Pulse rate greater than 140 bpm or less than 100 bpm.
- 4. Signs that the infant is not following moving objects.
- 5. Sudden vomiting or sudden drowsiness.

97. The nurse receives a report of a serum potassium level on an infant of 6.0 mEq/L. The nurse should:

- 1. Notify the physician of the abnormal level.
- 2. Call the laboratory to see how the specimen was obtained.
- 3. Connect the infant to a cardiac monitor.
- 4. Check the infant's last 24-hour output.

98. A client with suicidal thoughts is admitted to an adult inpatient behavioral health unit. What should the nurse do **first**?

- 1. Initiate suicide precautions with face-to-face observation of the client at all times.
- 2. Place the client on suicide watch and have a family member remain with the client.
- 3. Question the client further about his suicidal thoughts and plans.
- 4. Confine the client to his room and post a staff member at the door to observe his actions.

99. The nurse manager in a labor and delivery unit is making rounds on a client in early labor. Which of the following indicate that safety procedures are being implemented for this client? Select all that apply.

- 1. Bed in low position.
- 2. I.V. rates at ordered level.
- 3. Mother lying flat on back, if comfortable.
- 4. Client satisfied with support system present.
- 5. Client reports pain is tolerable.
- 6. Continuous fetal monitoring.

100. A nurse is planning care for a regressed, chronically ill client diagnosed with schizophrenia. What is the **most** appropriate milieu?

- 1. Confrontation and peer pressure to break down the client's denial.
- 2. Reminder that all clients must participate fully in unit self-governance.
- 3. Required attendance at group activities with equal participation from all clients.
- 4. Nurturance and supportive interaction focusing on individual needs.

101. Assessment of a primigravid client in active labor reveals cervical dilation at 9 cm with complete effacement and the fetus at +1 station. Which of the following should the nurse do when the physician orders meperidine (Demerol) 50 mg I.M. for the client?

- 1. Administer the medication in the left ventrogluteal muscle.
- 2. Be certain that naloxone (Narcan) is at the client's bedside.
- 3. Ask the physician to validate the dosage of the drug.
- 4. Refuse to administer the medication to the client.

102. A client has been hospitalized with a diagnosis of myasthenia gravis. A friend is visiting the client during lunch. The nurse enters the room after the client recovered from choking on lunch. What should the nurse do **next**?

- 1. Instruct the client to sit at a 30-degree angle in bed when eating.
- 2. Tell the client to swallow when her chin is tipped down on her chest.
- 3. Remind the client to rest after eating.
- 4. Encourage the client to eat alone.

103. A nurse is assessing a client with a brain injury. What is a client's cerebral perfusion pressure (CPP) when the blood pressure (BP) is 90/50 mm Hg and the intracranial pressure (ICP) is 21?
_____ mm Hg.

104. A client with a T2-to-T3 spinal cord injury suddenly complains of a throbbing headache and blurred vision. The nurse assesses that he is flushed and sweating on his upper trunk and face, and the hairs on his arms are raised. What should the nurse do **first**?

- 1. Raise the head of the bed.
- 2. Assess for hypotension.
- 3. Check the client for a distended bladder.
- 4. Logroll the client to see if he is lying on a foreign object.

105. A 17-year-old unmarried primigravida client at 10 weeks' gestation tells the nurse that her family doesn't have much money and her dad just got laid off from his job. Which of the following would be the nurse's **most** appropriate action?

- 1. Instruct the client in methods for low-cost, highly nutritious meal preparation.
- 2. Determine whether the client qualifies for state assistance programs.
- 3. Refer the client to a social worker for enrollment in the Women, Infants, and Children (WIC) program.
- 4. Ask the client if she has a job and the amount of income earned.

106. A client has impairments in immediate recall and short-term memory. A nurse is planning for the client's daily activities. Which action by the nurse would be **most** effective?

- 1. Write out the client's schedule in large print, and show the client where the schedule is placed.
- 2. Describe each activity and the time of the events at the beginning of the day.
- 3. Lead the client to each activity if he does not attend on time.
- 4. Tell the client about each activity 10 minutes before it begins.

107. A 17-year-old male client is being admitted to the adolescent psychiatric unit. He was brought in by the police after beating up two male peers. The client says, "They said I was gay because I had sex with an older neighbor when I was 8 years old. I am not gay!" Which of the following nursing interventions would be appropriate? Select all that apply.

- 1. Monitor the client's level of anger and potential aggression.
- 2. Help the client express anger safely.
- 3. Assist the client in processing his feelings about the sexual abuse.
- 4. Ask the client if he would like to attend a support group.
- 5. Discuss the client's attitude about going to jail after discharge.

108. The nurse has been assigned to care for several postpartum clients and their neonates on a birthing unit. Which of the following clients should the nurse assess **first**?

- 1. A multiparous client at 48 hours postpartum who is being discharged.
- 2. A primiparous client at 2 hours postpartum who delivered a term neonate vaginally.
- 3. A multiparous client at 24 hours postpartum whose infant is in the special care nursery.
- 4. A primiparous client at 48 hours after cesarean delivery of a term neonate.

109. A client is admitted to the hospital with malaise, headache, and cough followed by fever, chills, dyspnea, chest discomfort, myalgia, anorexia, vomiting, and diarrhea. The physician makes the diagnosis of legionellosis (legionnaires' disease). The client asks, "How did I get this?" Which response by the nurse is the **most** accurate?

- 1. "The bacteria thrive in warm water environments and are inhaled from contaminated water droplets."
- 2. "You inhaled the bacteria from secondary smoke."
- 3. "As ceiling fans circulate, bacteria are dispersed into the air."
- 4. "You may have swallowed contaminated water."

110. A client is scheduled to undergo an upper GI series. Which of the following instructions should the nurse give the client in preparation for the test? Select all that apply.

- 1. "You will need to take a stool softener before the test to promote evacuation of the barium."
- 2. "Do not eat or drink for 8 hours before the test."
- 3. "You can expect white stools for about 48 hours after the test."
- 4. "You will experience mild stomach pain during the test."
- 5. "It is okay for you to smoke before the test."

111. To improve the accuracy of client identification, the nurse must use at least two identifiers when providing care, treatment, or services. Which of the following are appropriate? Select all that apply.

- 1. Room number.
- 2. Bed number.
- 3. Medical record number.
- 4. Name band.
- 5. Social security number.

112. A client with metastatic cancer of the liver is concerned about his progress. Which of the following nursing interventions is **most** appropriate?

- 1. Provide information for the client to consider a liver transplantation.
- 2. Assure the client that the prescribed medications will shrink all tumor sites.
- 3. Explain the effects of chemotherapy.
- 4. Place emphasis on providing symptomatic and comfort measures.

113. The nurse is preparing to give an I.M. injection. Which of the following sites has the **least** amount of blood vessels and major nerves located in the area?

- 1. Deltoid.
- 2. Dorsogluteal.
- 3. Vastus lateralis.
- 4. Triceps.

114. The nurse is planning to teach the client how to properly use a metered-dose inhaler to treat asthma. Which of the following instructions should the nurse include in the teaching plan?

- 1. Rinse the mouth after each use of a steroid inhaler.
- 2. Inhale quickly when administering the medication.
- 3. Inhale the medication and then exhale through the nose.
- 4. Cough and deep-breathe before inhaling the medication.

115. A client is receiving a transfusion of packed red blood cells. Which of the following actions should the nurse implement to safely administer the blood?

- 1. Keep the blood refrigerated on the nursing unit until ready to administer.
- 2. Stay with the client during the first 15 minutes to detect signs or symptoms of a reaction.
- 3. Do not infuse blood that has been hanging for more than 6 hours.
- 4. Administer the blood quickly to prevent wasting it if the client develops a fever.

116. A client is receiving a blood transfusion when he begins to complain of difficulty breathing. The nurse notes an elevated blood pressure and a cough. Based on these signs, the nurse should prepare to manage which of the following complications?

- 1. Anaphylactic reaction.
- 2. Circulatory overload.
- 3. Sepsis.
- 4. Acute hemolytic reaction.

117. A client has had sucralfate (Carafate) ordered as treatment for peptic ulcer disease. Which of the following statements indicates that the client understands how to take the medication?

- 1. "I should take the Carafate every evening at bedtime."
- 2. "It is important that I take this drug on an empty stomach."
- 3. "I should avoid milk products while taking this drug."
- 4. "I should have my hemoglobin checked monthly while taking Carafate."

118. During the admission interview, an adult client reveals that, as a child, she was sexually abused by her uncle and a male cousin. She reports that when she has flashbacks of this abuse she cuts her arms, legs, and abdomen. In addition to having the client sign a no-harm contract, which nursing intervention is **most** important?

- 1. Assist the client with finding safe ways to express her anger.
- 2. Talk with the client about confronting her uncle and cousin directly.
- 3. Defer talking about the abuse to prevent further self-mutilation.
- 4. Discuss the possibility of the client suing her relatives for their abuse.

119. An adult client has bacterial conjunctivitis. What should the nurse teach him to do? Select all that apply.

- 1. Use warm saline soaks four times per day to remove crusting.
- 2. Apply topical antibiotic without touching the tip of the tube to his eye.
- 3. Wash his hands after touching his eyes.
- 4. Avoid touching his eyes.
- 5. Observe isolation procedures and confine himself to his bedroom until the redness in the eye disappears.

120. Which of the following actions by the nurse will **most** likely ensure that the correct client receives a medication? Select all that apply.

- 1. Have the client state his or her name.
- 2. Check the name on the arm band with the name on the medication.
- 3. Learn to recognize the client.
- 4. Check the client's room number.
- 5. Compare the date of birth on the client's chart to the date of birth on the client's armband.

121. A nurse is counseling a mother with young children after the mother left her abusive husband 6 months ago. The mother says, “My 6-year-old, Kevin, is starting to act just like his father. I just don’t know how to handle this.” Which response by the nurse is **most** appropriate?

- 1. “You’ll have to limit Kevin’s contact with his father.”
- 2. “Counseling for Kevin would be helpful.”
- 3. “Most boys outgrow these behaviors.”
- 4. “Setting limits on his behavior is all you need to do now.”

122. The nurse manager is developing a “read-back” procedure to reduce medication administration errors. Which of the following are purposes of the “read-back” requirement? Select all that apply.

- 1. To prohibit orders and test results from being communicated verbally or by telephone.
- 2. To make sure that orders and test results that are communicated verbally or by telephone are clear to the receiver of the information.
- 3. To make sure that orders and test results that are communicated verbally or by telephone are confirmed by the individual giving the information.
- 4. To minimize the risk of non-authorized personnel from giving orders which are communicated verbally or by telephone.
- 5. To encourage the use of electronic medical records.

123. A 13-year-old male was kidnapped and held for ransom by two criminals. His parents asked to have him admitted to the adolescent psychiatric unit. He is sleep-deprived, filthy, alternating between sobbing and making threats to kill his captors, suspicious, and easily startled. He signs a no harm contract and then asks to go to sleep. What is the **best** initial plan for this client?

- 1. Encourage him to talk with the Federal Bureau of Investigation (FBI) about the crime details.
- 2. Develop trust and allow him to talk about his memories and feelings.
- 3. Help him and his parents prepare for the future trial.
- 4. Discourage him from making threats toward his captors.

124. A 16-year-old primiparous client has decided to place her baby for adoption. The adoptive parents are on their way to the hospital when the mother says, “I want to see the baby one last time.” Which of the following should the nurse do?

- 1. Tell the client that it would be best if she didn’t see the baby.
- 2. Allow the client to see the baby through the nursery window.
- 3. Contact the physician for advice related to the client’s visitation.
- 4. Allow the client to see and hold the baby for as long as she desires.

125. A 10-year-old child is admitted with a brain tumor. Which assessment made by the nurse is **most** critical to report to the child’s physician?

- 1. Vomiting after lunch.
- 2. Difficulty in recalling the day of the week.
- 3. Blood pressure of 102/62 mm Hg.
- 4. 100 mL of concentrated urine voided at one voiding.

126. The nurse is teaching a 17-year-old girl who has a severe gonorrheal infection. The nurse realizes that the girl understands the implications of her disease when she tells the nurse:

- 1. “Once I’m treated, I’ll have immunity.”
- 2. “My partner doesn’t need treatment.”
- 3. “I won’t have any more problems once I learn to protect myself.”
- 4. “I could have trouble getting pregnant.”

127. The nurse-manager on the medical unit is teaching the staff about the medication reconciliation policy. The nurse teaches the staff that reconciliation is needed to ensure that clients are on the correct medications in which situations? Select all that apply.

- 1. Admission to the hospital.
- 2. Transfer to the nursing home.
- 3. Transfer of a client from surgery to the surgical unit.
- 4. Admission to a home health agency from the hospital.
- 5. Move from a double room to a single room on the same unit.

128. A client was treated for a streptococcal throat infection 2 weeks ago. The client now has been diagnosed with acute poststreptococcal glomerulonephritis. The client asks the nurse how he could have prevented this condition. What should the nurse tell the client?

- 1. “See your physician for an early diagnosis and treatment of a sore throat.”
- 2. “As long as you do not have a fever, it is sufficient to gargle daily with an antibacterial mouthwash.”
- 3. “You may continue to utilize the previously prescribed antibiotics until they are gone.”
- 4. “Unscented bar soap may be used in showers.”

129. Assessment of a primigravid client in active labor reveals a cervix dilated to 5 cm and completely effaced, with the fetus at –1 station. The client has indicated that she wants a “natural childbirth” with no analgesia or anesthesia. The client’s husband has been present since their arrival at the birthing unit. The physician enters the room and tells the client that it is time for an epidural anesthetic. Which of the following would be the nurse’s **best** action at this time?

- 1. Ask the client if she desires an epidural anesthetic.
- 2. Tell the physician that the client desires a “natural childbirth.”
- 3. Tell the client that her labor will be more comfortable with an anesthetic.
- 4. Ask the client to discuss this with her husband and then make a decision.

130. A client is ready to be discharged from same-day surgery following an inguinal hernia repair. Which criteria must the client meet before the nurse can discharge the client?

- 1. The client has transportation home via a taxicab.
- 2. The client has pain no greater than 5 on a scale of 1 to 10.
- 3. The client can walk to the bathroom by himself.
- 4. The client states he will urinate later when he has more fluids.

131. The nurse is administering eyedrops to a client with glaucoma. Which of the following is a correct technique for instilling the eyedrops? The eyedrops are placed:

- 1. In the lower conjunctival sac.
- 2. Near the opening of the lacrimal ducts.
- 3. On the cornea.
- 4. On the scleral surface.

132. A client has an anaphylactic reaction to penicillin that results in respiratory distress. Which of the following medications should the nurse anticipate administering?

- 1. Dopamine (Intropin).
- 2. Diphenhydramine (Benadryl).
- 3. Cimetidine (Tagamet).
- 4. Epinephrine.

133. The nurse is designing a benchmarking study to gather information about nursing care practices for wound care. Which of the following sources of information are used for benchmarking? Select all that apply.

- 1. Government reports.
- 2. Literature reviews.
- 3. Standard-setting organizations.
- 4. Databases.
- 5. Clinical organization recommendations.

134. A client is using an over-the-counter nasal spray containing pseudoephedrine to treat allergic rhinitis. Which instruction about this medication would be **most** appropriate for the nurse to provide for the client?

- 1. Prolonged use of nasal spray can lead to nasal infections.
- 2. Pseudoephedrine is an addictive drug and must be used cautiously.
- 3. Overuse of pseudoephedrine can lead to increased nasal congestion.
- 4. A common side effect of pseudoephedrine nasal spray is thrush.

135. A 6-year-old child is admitted for an appendectomy. What is the **most** appropriate way for the nurse to prepare the child for surgery?

- 1. Explain how to use a patient-controlled analgesia (PCA) pump for pain control.
- 2. Permit the child to play with the blood pressure cuff, electrocardiogram (ECG) pads, and a face mask.
- 3. Show the child a video about the surgery.
- 4. Show the child a visual analog scale (VAS) based on a scale from 0 to 10.

136. The nurse is working on a hospital’s birthing unit when a primigravid client in active labor is ordered to receive meperidine (Demerol) 75 mg I.M. As the nurse enters the medication room, the nurse observes a female coworker slipping a vial of morphine into the side pocket of her uniform. Which of the following actions would be **most** appropriate?

- 1. Contact the hospital’s security chief.
- 2. Notify the supervisor of the unit.
- 3. Tell the coworker of the incident.
- 4. Notify the federal drug agents about the incident.

137. Which of the following should the nurse include when teaching the family and a client who was prescribed benzotropine (Cogentin), 1 mg P.O. twice daily, about the drug therapy?

- 1. The drug can be used with over-the-counter cough and cold preparations.
- 2. The client should not discontinue taking the drug abruptly.
- 3. Antacids can be used freely when taking this drug.
- 4. Alcohol consumption with benzotropine therapy need not be restricted.

138. Which of the following should the nurse include in a teaching plan that addresses the adverse effects of antipsychotic medication?

- 1. Information about all potential adverse effects.
- 2. Research data about rare adverse effects.
- 3. Adverse effects that can be seen or felt.
- 4. Percentages associated with each adverse effect.

139. A client has nephrotic syndrome. To aid in the resolution of the client's edema, the physician orders 25% albumin. In addition to an absence of edema, the nurse should evaluate the client for which expected outcome?

- 1. Crackles in the lung bases.
- 2. Blood pressure elevation.
- 3. Cerebral edema.
- 4. Cool skin temperature in lower extremities.

140. A client has polycystic kidney disease. The client asks the nurse, "How did I get these fluid-filled bubbles on my kidneys? I have not had any X-ray type tests." How should the nurse respond to help the client understand risk factors for this disease process?

- 1. "Second-hand smoke puts you at greater risk for developing cysts."
- 2. "Exposure to dyes used to color fruits and vegetables increases the risk of polycystic kidney disease."
- 3. "There is a higher incidence of polycystic kidney disease among blood relatives."
- 4. "Drinking alcohol daily allows the kidneys to develop cysts."

141. A nurse is administering I.V. fluids to a dehydrated client. When administering an I.V. solution of 3% sodium chloride, what should the nurse do? Select all that apply.

- 1. Measure the intake and output.
- 2. Inspect the jugular veins for distention.
- 3. Evaluate the client for neurologic changes.
- 4. Force fluids, especially water.
- 5. Insert an indwelling urinary catheter.

142. The nurse is working on a birthing unit that has several unlicensed assistive personnel (UAP). The nurse determines that the UAP understands the type of information to report to the nurse when the the UAP reports which of the following about one of the clients?

- 1. An episode of nausea after administration of an epidural anesthetic.
- 2. Contractions 3 minutes apart and lasting 40 seconds.
- 3. Evidence of spontaneous rupture of the membranes.
- 4. Sleeping after administration of I.V. nalbuphine (Nubain).

143. A 9-year-old child is scheduled for an electromyelogram. To prepare the child for this procedure, what should the nurse do?

- 1. Wait until just before the test to tell the child what will be done.
- 2. Ask the child to draw a picture of the body structures involved.
- 3. Show the child the equipment that will be used in the test.
- 4. Verbally explain what will be done during the test.

144. The nurse is planning a program about women's health and cancer prevention for a community health fair. The nurse should include information about? Select all that apply.

- 1. Regular self-exams of the breast and vulva are important self-care activities.
- 2. Cancer can be prevented by removing precancerous lesions of the vulva, cervix, or endometrium.
- 3. Girls, age 11 to 12, should receive immunization for human papilloma virus (HPV) to prevent cervical cancer.
- 4. Smoking cessation reduces the risk of cervical cancer.
- 5. There is limited evidence that cancer in women is inherited.

145. A 10-year-old client with rheumatic fever is on bed rest. Which of the following would be an appropriate diversion activity for the nurse to encourage?

- 1. Watching television with his roommate.
- 2. Coloring picture books with his brother.
- 3. Keeping up with his school work.
- 4. Building a bird house.

146. Clients who are receiving total parenteral nutrition (TPN) are at risk for development of which of the following complications?

- 1. Hypostatic pneumonia.
- 2. Pulmonary hypertension.
- 3. Orthostatic hypotension.
- 4. Fluid imbalances.

147. The nurse is to administer a bolus starting dose of heparin to a child who is taking penicillin. What should the nurse do? Select all that apply.

- 1. Check that the dose is appropriate for the child's weight.
- 2. Note that the onset of the medication will be immediate.
- 3. Follow the administration of the bolus of heparin with an I.V. infusion of heparin 10 units/kg/hour.
- 4. Monitor partial thromboplastin time (PTT).
- 5. Discontinue the penicillin until the PTT is at a therapeutic level.

148. The client is receiving propantheline bromide (Pro-Banthine) to treat cholecystitis. The nurse should evaluate the client's response to the medication by observing for which of the following adverse effects?

- 1. Urine retention.
- 2. Diarrhea.
- 3. Hypertension.
- 4. Diaphoresis.

149. The nurse is preparing to start an I.V. infusion. Before inserting the needle into a vein, the nurse should apply a tourniquet to the client's arm to accomplish which of the following?

- 1. Distend the veins.
- 2. Stabilize the veins.
- 3. Immobilize the arm.
- 4. Occlude arterial circulation.

150. Prochlorperazine (Compazine) is prescribed postoperatively. The nurse should evaluate the drug's therapeutic effect when the client expresses relief from which of the following?

- 1. Nausea.
- 2. Dizziness.
- 3. Abdominal spasms.
- 4. Abdominal distention.

151. A 17-year-old client has been admitted to the hospital for a biopsy to confirm the diagnosis of bone cancer. The nurse should assess the client for which conditions? Select all that apply.

- 1. Cough.
- 2. Dyspnea.
- 3. Pain.
- 4. Swelling.
- 5. Fever.
- 6. Anorexia.
- 7. Decreased range of motion.

152. A nurse on the labor-and-delivery unit transfers a primiparous client and her term neonate to the mother-baby unit 2 hours after the client delivered the neonate by vaginal delivery. Which of the following information is a **priority** for the nurse to report to the nurse receiving the client on the mother-baby unit?

- 1. Firm fundus when gentle massage is used.
- 2. Evidence of bonding well with the neonate.
- 3. Labor that lasted 12 hours with a 1-hour second stage.
- 4. Temperature of 99° F (37.4° C) and pulse rate of 80 bpm.

153. A client who underwent cardiac surgery 2 days ago is recovering well. His wife, who is assisting with his care, says, "He is doing too much. I told him to let me help, but he won't let me." The nurse says to the wife, "It sounds like you need to feel you can be more helpful to him." In order to make her nonverbal behavior complement her words, the nurse should:

- 1. Direct the eyes at the client.
- 2. Direct the body and eyes at the wife and client.
- 3. Avoid direct eye contact with the client and wife.
- 4. Shift the eyes back and forth between the client and wife.

154. A nurse is having difficulty establishing a relationship with an aggressive client. What strategy will **most** likely improve the relationship?

- 1. The nurse and the client agree to work to improve their involvement in the therapeutic relationship.
- 2. The nurse establishes goals for having only positive interactions with the client.
- 3. The nurse agrees to be submissive so the client can dominate the relationship.
- 4. The nurse seeks assistance from colleagues to become more aware of the quality of the interactions and more sensitive to the dynamics of communication.

155. The charge nurse on the postpartum unit has received report about a client with a fetal demise who has just delivered and will be ready for transfer out of Labor and Delivery in about 2 hours. The client has asked her primary nurse if she can stay on the obstetrical unit since she has found support from the nursing staff there. What action should the charge nurse on the postpartum unit take?

- 1. Request a room for this client on a unit without newborns.
- 2. Ask the nurse in labor and delivery to discharge the mother as soon as she is physically able to leave.
- 3. Talk to the mother first and decide on a location that is mutually agreeable.
- 4. Admit the mother to a private room on the postpartum unit.

156. A nurse is about to conduct a sexual history for a 16-year-old female who is accompanied by her mother. What is an appropriate question for the nurse to ask this client or her mother?

- 1. "What do you think about having your mother leave the room now?"
- 2. "Mother, do you think your daughter is sexually active?"
- 3. "Mother, I am going to ask you to wait a few minutes in the waiting room now so I can complete the health history with your daughter."
- 4. "The two of you seem like you share everything. I am going to ask questions about sexual history now."

157. A nurse is admitting an older female client to the gynecology surgical unit. When the nurse asks the client what medication she is taking at home, the client responds that she is taking a little red pill in the morning and a white capsule at night for her blood pressure. What action by the nurse is focused on safe, effective care of this client?

- 1. Consult the pharmacist regarding identification of the medications.
- 2. Show pictures to the client from the *Physician's Desk Reference* to identify the medications.
- 3. Consult the previous medical record from 2 years ago and notify the physician regarding medications that must be ordered.
- 4. Ask a family member to bring the medications from home in the original vials for proper identification and administration times.

158. A client who had undergone an abdominal hysterectomy is in the recovery room. The surgeon has ordered a 250-mL bolus of normal saline over 1 hour to replace blood loss. The I.V. solution infusing in the client was 1,000 mL normal saline with 40 mEq of potassium chloride at 100 mL/hour. The nurse should: Select all that apply.

- 1. Increase the I.V. infusion rate to 250 mL/hour for 1 hour.
- 2. Add 250 mL of normal saline to the current infusion bag and continue at 100 mL/hour.
- 3. Connect a 250-mL bag of normal saline to the Y-connection and calculate to infuse over 1 hour.
- 4. Contact the physician regarding continuation of the primary I.V. infusion during the bolus infusion.
- 5. Administer the normal saline bolus via an I.V. infusion pump.

159. The nurse is working in a newborn nursery and caring for several neonates. Precautions that should be taken to prevent an infant abduction include which of the following?

- 1. Notifying the hospital's security staff about anyone who appears unusual.
- 2. Taking several neonates to their mothers at the same time.
- 3. Placing the infant near the doorway of the mother's room.
- 4. Contacting the hospital's security staff if an exit alarm is triggered.

160. Clozapine (Clozaril) therapy has been initiated for a client with schizophrenia who has been unresponsive to other antipsychotics. The client states, "Why do I have to have a blood test every week?" Which of the following responses by the nurse would be **most** appropriate?

- 1. "Weekly blood tests are necessary to determine safe dosage and to monitor the effect of the medication on the blood."
- 2. "Weekly blood tests are done so that you can receive another week's supply of the medication."
- 3. "Your physician will want to know how well you are progressing with the medication therapy."
- 4. "Everyone taking clozapine (Clozaril) has to go through the same procedure because it is required by the drug company."

161. The nurse administers an intradermal injection to a client. Proper technique has been used if the injection site demonstrates which of the following?

- 1. Minimal leaking.
- 2. No swelling.
- 3. Tissue pallor.
- 4. Evidence of a bleb.

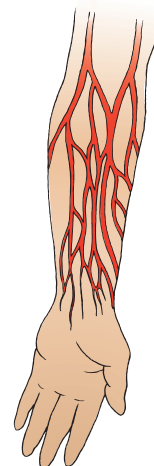
162. The sudden onset of which of the following indicates a potentially serious complication for the client receiving an I.V. infusion?

- 1. Noisy respirations.
- 2. Pupillary constriction.
- 3. Halitosis.
- 4. Moist skin.

163. The nurse is planning to initiate a blood transfusion. Which of the following solutions should the nurse select to prime the tubing when preparing to administer the blood?

- 1. Lactated Ringer's solution.
- 2. Normal saline.
- 3. 5% dextrose in half-normal saline.
- 4. 5% dextrose in water.

164. When preparing to insert an I.V. catheter to administer fluids to a client who is going to surgery, the nurse selects the median cubital vein. Identify the location of the median cubital vein on the illustration below.



165. The mother of a 28-year-old client who is taking clozapine (Clozaril) states, “Something is wrong. My son is drooling like a baby.” Which of the following responses by the nurse would be **most** helpful?

- 1. “I wonder if he’s having an adverse reaction to the medicine.”
- 2. “Excess saliva is common with this drug; here’s a paper cup for him to spit into.”
- 3. “Don’t worry about it; this is only a minor inconvenience compared to its benefits.”
- 4. “I’ve seen this happen to other clients who are taking Clozaril.”

166. The physician is calling in an order for ampicillin for a neonate. The nurse should do which of the following? Select all that apply.

- 1. Write down the order.
- 2. Ask the physician to come to the hospital and write the order on the chart.
- 3. Repeat the order to the physician over the telephone.
- 4. Ask the physician to confirm that the order is correct.
- 5. Ask the nursing supervisor to cosign the telephone order as transcribed by the nurse.

167. A client taking clozapine (Clozaril) states, “I think I’m getting the flu. I have a fever and feel weak.” Which of the following should the nurse do **next**?

- 1. Tell the client to wait another day to see if other symptoms of the flu appear.
- 2. Advise the client to take over-the-counter medication for the flu.
- 3. Discuss the importance of maintaining an adequate fluid intake.
- 4. Report the client’s symptoms to the physician after taking the client’s temperature.

168. Which of the following medications should the nurse anticipate administering in the event of a heparin overdose?

- 1. Warfarin sodium (Coumadin).
- 2. Protamine sulfate.
- 3. Acetylsalicylic acid (ASA).
- 4. Atropine sulfate.

169. The nurse has administered aminophylline to a client with emphysema. The medication is effective when there is:

- 1. Relief from spasms of the diaphragm.
- 2. Relaxation of smooth muscles in the bronchioles.
- 3. Efficient pulmonary circulation.
- 4. Stimulation of the medullary respiratory center.

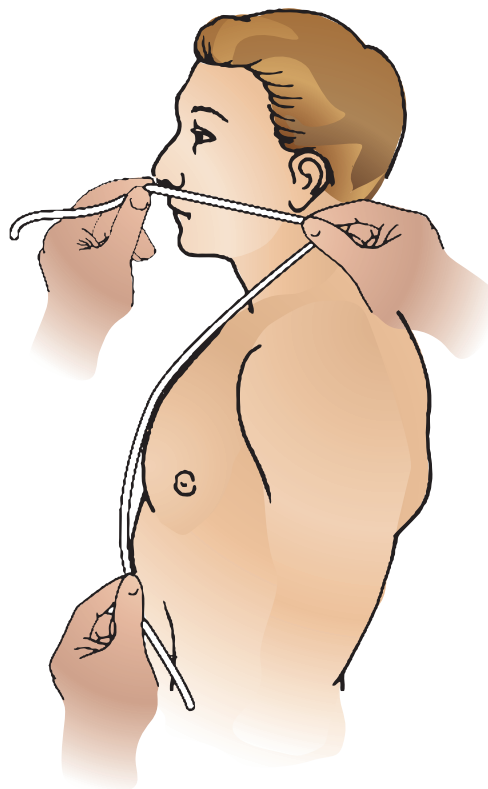
170. The nurse is conducting health assessments for school-age children. A characteristic behavior of a 7-year-old girl is that she:

- 1. Likes to play only with other girls.
- 2. Prefers to play with her sister.
- 3. Prefers to play team games.
- 4. Likes to play alone.

171. A nurse is planning care for a 7-year-old who is hospitalized for a hernia repair. The nurse should assess the client for which of the following fears common in this age group?

- 1. Separation from parents.
- 2. Trying something new.
- 3. Injury and pain.
- 4. Opposite-sex relationships.

172. Before inserting a nasogastric (NG) tube in an adult client, the nurse estimates the length of tubing to insert. Identify the point on the illustration where the nurse would end the measurement.



173. A woman who delivered a healthy baby 6 hours ago tells the nurse that she is having cramps in her legs. Upon further assessment, the nurse identifies leg pain on dorsiflexion. The nurse should:

- 1. Tell the woman to massage the area.
- 2. Apply warm compresses to the area.
- 3. Instruct the woman on how to do ankle pumps.
- 4. Notify the physician.

174. The nurse interprets the rhythm strip below from a client's bedside monitor as which of the following?

- 1. Normal sinus rhythm.
- 2. Sinus tachycardia.
- 3. Ventricular tachycardia.
- 4. Ventricular fibrillation.

175. A young adult is hospitalized with a seizure disorder. The client, who is in a bed with padded side rails, has a tonic-clonic seizure. In what order should the nurse take the following actions?

1. Loosen clothing around the client's neck.

2. Turn the client on his or her side.

3. Clear the area around the client.

4. Suction the airway.

176. The nurse interprets the rhythm strip below from a client's bedside monitor as which of the following?

- 1. Normal sinus rhythm.
- 2. Sinus tachycardia.
- 3. Atrial fibrillation.
- 4. Ventricular tachycardia.

177. The nurse delegates the care of a multiparous client who delivered a viable term neonate vaginally 30 hours ago and is preparing to be discharged to a licensed practical nurse (LPN). The nurse should instruct the LPN to notify the nurse if the client exhibits which of the following?

- 1. Pulse rate of 100 bpm.
- 2. Oral temperature of 99° F (36.8° C).
- 3. Excessive perspiration during the assessment.
- 4. Frequent voiding in large amounts.

178. An woman with a history of a left radical mastectomy is being admitted for abdominal surgery. The woman has a swollen left arm. The nurse should:

- 1. Take the blood pressure only in the unaffected arm.
- 2. Start an I.V. line in the affected arm.
- 3. Encourage a dependent position of the affected arm.
- 4. Allow blood draws in the affected arm.


179. A 36-month-old child weighing 44 lb is to receive ceftriaxone (Rocephin) 2 g I.V. every 12 hours. The recommended dose of Rocephin is 50 to 75 mg/kg/day in divided doses. The nurse should:

- 1. Administer the medication as ordered.
- 2. Administer half the ordered dose.
- 3. Call the laboratory to check the therapeutic serum level of Rocephin.
- 4. Withhold administering the Rocephin and notify the child's physician.

180. The nurse has provided an in-service presentation to ancillary staff about standard precautions on the birthing unit. The nurse determines that one of the staff members needs further instructions when the nurse observes which of the following?

- 1. Use of protective goggles during a cesarean delivery.
- 2. Placement of bloody sheets in a container designated for contaminated linens.
- 3. Wearing of sterile gloves to bathe a newly delivered neonate at 1 hour of age.
- 4. Disposal of used scalpel blades in a puncture-resistant container.


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. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

1. 3. The head of the bed should be elevated 30 degrees to promote venous drainage and decrease intracranial pressure. The client's head should be in a midline, or neutral, position. Clients with supratentorial surgery should be positioned on the nonoperative side to prevent displacement of the cranial contents by gravity.

 CN: Reduction of risk potential;
CL: Synthesize


2. 4. A trained medical interpreter is required to ensure safety, accuracy of history data, and client confidentiality. The medical interpreter knows the client's rights and is familiar with the client's culture. Using the family member as interpreter violates the client's confidentiality. Using the nursing assistant or limited Spanish and nonverbal communication do not ensure accuracy of interpretation and back-translation into English.

 CN: Management of care; CL: Synthesize

3. 1, 3, 4, 5. Home care for a client with a total laryngectomy should include a high-humidity environment, laryngectomy tube care and suctioning, speech rehabilitation, and smoking cessation. The client is not restricted to a bland diet.

 CN: Management of care; CL: Create

4. 2. Administering acetaminophen to the client with a post ECT headache is the best action. Stating a headache is common after ECT and that napping will help the client feel better may be true, but it does not offer the client pain relief. Telling the client to eat breakfast and then to let the nurse know how the client feels conveys a lack of understanding to the client and dismisses the client's concern.

 CN: Psychosocial adaptation;
CL: Synthesize

5.

5:30	2
6:00	3
6:30	1
7:00	4

The two tasks/orders that have time frames associated with them are the accucheck and insulin, and the magnesium sulfate blood draw. The fetal monitor strip can be obtained when convenient. Checking documentation and seeing each client should be done so that any client needs can be met and documentation completed prior to the 7 a.m. accucheck and insulin, yet close enough to the end of the shift that there will be minimal changes before change of shift.

 CN: Management of care; CL: Synthesize

6. 4. An 18-month-old child should be able to say 10 or more words. Lack of speech development may indicate a lack of social stimulation, a hearing deficiency, or developmental delay. Referring the child for an evaluation may increase the child's chance of reaching his potential. A 4-month-old child with a healthy central nervous system and normal mental development should be able to laugh out loud if his environment has been caring and his needs are met safely and consistently. Children at age 10 months should be able to say the words "dada" and "mama" in response to the appropriate person. A 1-year-old child should have the ability to speak 3 to 5 words plus "mama" and "dada."


 CN: Health promotion and maintenance;
CL: Analyze

7. 1. Phenylketonuria is a disease that is carried on the recessive genes of each parent. In order to be transmitted to a newborn, the infant inherits a recessive gene from each parent. Control of the disease is

by reduction of the amino acid phenylalanine, which is present in all protein foods. The disease cannot be cured, but controlled. With each pregnancy, there is a 25% chance a child will inherit the disease.

 CN: Reduction of risk potential;
CL: Apply

8. 4. The nurse should convey empathy and invite the client to share more about her thoughts and feelings so that the nurse can assess the mother for possible postpartum depression, which usually occurs between 2 weeks and 3 months after the baby's birth but also can occur later. Postpartum depression is a mood disorder with symptoms of tearfulness, mood swings, despondency, feelings of inadequacy, inability to cope with the baby, and guilt about performance as a mother. Postpartum depression commonly goes undetected because of poor recognition and lack of knowledge. Hormonal changes during and after childbirth may account for some of the symptoms; however, the nurse should not assume that that is the case. Stating the client's husband and family should help her is an assumption that they are not and dismisses the client's concerns. Saying most new mothers feel the same way minimizes the client's concerns and decreases the likelihood of further disclosure by the client.


 CN: Psychosocial adaptation;
CL: Synthesize

9. 4 tablets

$$1,000 \text{ mg} = 1 \text{ g}$$

$$2 \text{ g} = 2,000 \text{ mg}$$

$$2,000 \text{ mg} \div 500 \text{ mg} = 4$$

 CN: Pharmacological and parenteral therapies; CL: Apply

10. 2, 3. Huntington's disease, or *Huntington's chorea*, is an autosomal dominant genetic neurologic disease that affects descendants of an affected person at a 50% rate. Huntington's disease does not skip generations and affects men and women equally. Huntington's disease is genetically transmitted on chromosome 4, and death usually results from respiratory complications related to aspiration.

 CN: Physiological adaptation; CL: Apply


11. 2. Liquids found on the floor should be removed immediately. The nurse should first put on gloves and then wipe up the liquid. Following removal, Environmental Services should be contacted to thoroughly cleanse the floor with a disinfectant solution. Placing paper towels over the drops is a safety hazard. "Wet floor" signs will be posted after the floor is cleansed by Environmental Services.

 CN: Safety and infection control;
CL: Synthesize

12. 2, 3, 4. A client who has been admitted for numbness and tingling in his lower extremities that advances upward, especially after having a viral infection, has clinical manifestations characteristic of Guillain-Barré syndrome. The health care provider must be notified of the change immediately because this disease is progressively paralytic and should be treated before paralysis of the respiratory muscles occurs. The nurse must assess the client continuously to determine how fast the paralysis is advancing. The family does not need to be called in to visit until the client is stabilized and emergency equipment is placed at the bedside. Performing ankle pumps will not relieve the numbness or change the course of the disease.

 CN: Management of care; CL: Synthesize

13. 3. The spinal cord connects the brain to the periphery. The thalamus is located in the midbrain and integrates all sensory impulses except olfaction. The afferent impulses are received and then transmitted from the thalamus. Destruction or interruption of the neurosensory pathway results in loss of communication between the two systems. Monitoring the temperature of the bathwater is important because the client cannot feel whether the water is too hot or too cold. Damage to the thalamus does not result in loss of the corneal reflex. Loss of position and vibratory sense usually occurs with degeneration of the posterior column of the spinal cord; therefore, turning every 2 hours is critical to prevent skin breakdown related to increased capillary pressure. The nurse can give only the prescribed dosage of pain medication.

 CN: Physiological adaptation;
CL: Synthesize

14. 3. The client needs to know her request is being met but also should be informed that discharge will not be immediate and that the client's psychiatrist will be notified to discuss the matter with the client. While it is true that a client admitted voluntarily has the right to leave, the client cannot leave immediately. It is inaccurate that a lawyer or family member must request forms for release against medical advice. Although it is acceptable for the nurse to try to convince the client to stay, the mention of insurance implies the client is hospitalized because of having insurance, rather than the psychiatric issues being treated.


 CN: Management of care; CL: Synthesize

15. 1,2,4,5. Compliance with the Tarasoff rule involves wide notification and careful documentation of the notification. The nurse should notify the potential victim. The police must be notified, making it less possible for the client to follow through on his threat. The nurse must also notify


key administrators and service departments in the health care facility so they are aware of the issue and the potential hazards related to the client's threat. The client is not a threat to the ex-wife at this time so she does not need to be notified.

 CN: Management of care; CL: Synthesize


16. 1. The spinal cord connects the brain to the periphery. Destruction or interruption of the neurosensory pathway results in loss of communication between the two systems. Transection of the spinal cord renders the individual in a complete state of anesthesia below the level of injury. Tingling in the fingers may be related to spinal cord disease or to improper positioning of the extremity. Loss of position and vibratory sense usually occurs when the individual has degeneration of the posterior column of the spinal cord.

 CN: Physiological adaptation;
CL: Analyze


17. 3. Common pressure points in the side-lying position include the ears, shoulders, ribs, greater trochanter, medial and lateral condyles, and ankles. The sacrum, occiput, and heel are pressure points in the supine position.

 CN: Physiological adaptation;
CL: Analyze

18. 1, 2, 3. Goals for promoting healthy development in preschoolers include anticipatory guidance, helping parents understand their child's behavior, identifying deviations from the norm, and assessing parent-child interaction. No one can assess or determine the child's future development and trying to do so can limit the potential the child may achieve. Although learning to interact with others is important, sending the child to a day care center is not essential to promote healthy development. The nurse can encourage the parents to provide opportunities for the child to play with others.


 CN: Psychosocial adaptation; CL: Create

19. 1. Alarms on infusion pumps should be set at 5% above and 5% below the prescribed infusion rate. A wider range is not safe. The alarms must be set to indicate a change in the drip rate, not infiltration. Setting the alarms for the exact drip rate will cause the alarms to trigger when the client moves, and this exact range is not needed to alert the nurse to an unsafe rate.

 CN: Safety and infection control;
CL: Apply

20. 1. The client's physical needs are a priority in the nurse's plan of care. The lack of fluid and caloric intake can lead to dehydration and cardiac collapse. The lack of sleep and rest can lead to

exhaustion and death. Social, spiritual, and cultural needs are important client needs but not as important as the physical needs during an acute manic episode.

 CN: Psychosocial adaptation;
CL: Synthesize

21. 1, 2, 3. The alarm settings on infusion pumps should be verified at the time the infusion is started, at the beginning of each shift, and when the client is moved. The neonate can move in bed, but if the alarm is triggered, the nurse should verify the settings. Unless the neonate has moved or been taken out of the crib, it is not necessary to check alarm settings after the parents visit.

 CN: Safety and infection control;
CL: Apply

22. 3. Contacting the Security Department is a proactive response in a situation that may become more volatile. A soft voice by the nurse may not even be heard in this situation. To state, “Stop!” in this situation is not helpful and does not deal with the escalating risk. Once Security has been notified, the nurse should also report the incident to the supervisor.

 CN: Management of care; CL: Synthesize

23. 2. Thermoregulation of the neonate is a critical intervention for the nurse caring for neonates. A hat on the neonate conserves heat as the majority of heat is lost through the top of the head. Wrapping will also conserve heat and prevent heat loss. With the neonate lying against a crib wall, heat transfers away from the infant to the cooler surface (conduction). If the neonate is wet, the warmer water on the surface of the neonate evaporates to the cooler air (evaporation). If the neonate is lying in an open crib with a diaper on, the body naturally loses heat to the surrounding cooler air as it radiates from the warm body to the cooler room (radiation).

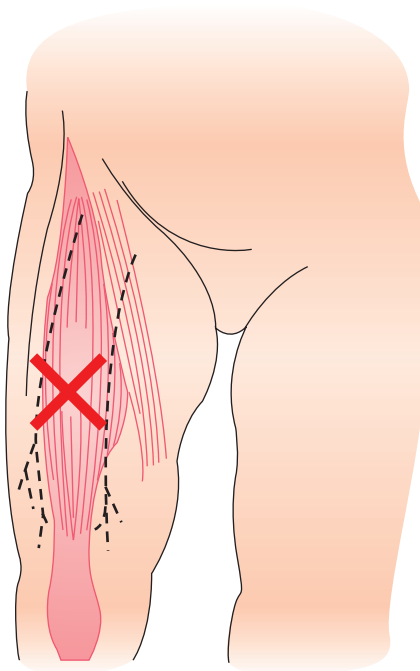
 CN: Management of care; CL: Synthesize

24. 2. When the blink reflex is absent or the eyes do not close completely, the cornea may become dry and irritated. Placing a patch over the eye is the most appropriate intervention to prevent eye injury. Making sure the client wears her eye-glasses at all times will not help protect the eye from injury. A once-per-shift intervention will not adequately relieve the potential for injury from a dry and irritating ocular environment. A normal saline solution should be used to moisten the eye, not tap water.


 CN: Health promotion and maintenance;
CL: Synthesize

25. The rectus femoris is a safe site for injections for infants. The site is free from most nerves and blood vessels. The nurse should use a needle that is 1 inch or smaller, and inject the needle at a 45-degree angle.


 CN: Safety and infection control;
CL: Apply



26. 1, 2, 3. The alarm settings on infusion pumps should be verified at the time the infusion is started, at the beginning of each shift, and when the client is moved. The child can move in bed or sleep, but if the alarm is triggered, the nurse should verify the settings.

 CN: Safety and infection control;
CL: Apply

27. 4. Social isolation is a concern for an older adult who has diminished hearing and vision. Feeling disoriented may be related to cognitive problems rather than diminished hearing and vision. Diminished hearing and vision is related to the aging process and does not result in impairment of the older adult's thought processes. The client with impaired hearing and vision is unlikely to experience sensory overload.


 CN: Psychosocial adaptation;
CL: Synthesize

28. 3. According to the Denver Developmental Screening Examination, a child age 2 years should have a vocabulary of 300 words, be able to combine two or three words, and ask for what he wants by name. By age 3, the child should have a vocabulary of 900 words and can use a complete sentence of


three or four words. A 1-year-old has a vocabulary of at least 8 words and can reference people and objects.

 CN: Health promotion and maintenance;
CL: Analyze


29. 1, 2, 3, 5. The nurse should ask the client with multiple sclerosis about areas of muscle weakness because baclofen may increase the weakness. The nurse should ask the client about a history of muscle spasms. Baclofen is effective against involuntary spasms resistant to passive movement for clients with multiple sclerosis and paralysis. Baclofen is not effective against the spasticity of cerebral origin, such as with cerebral palsy and Parkinson's disease. The nurse should ask the client about his liver and renal function because baclofen is metabolized and excreted by these organs. The nurse should check the laboratory values reflecting the function of the kidneys and liver, which include serum creatinine and blood urea nitrogen levels. The nurse should also check blood glucose levels because baclofen can increase blood glucose. Clients with diabetes taking antidiabetic medication may need to adjust the dosage. Potassium is not affected by the drug, so the nurse does not need to check the serum potassium level.

 CN: Pharmacological and parenteral therapies; CL: Apply

30. 1, 2, 4. The nurse should assess the client for signs of bone marrow depression, manifested by bruising or unusual bleeding, and signs of infection such as a sore throat. The nurse should also assess the client for signs of hepatic dysfunction, such as light-colored stool or dark-colored urine. Although the nurse may want to check the client's urinary function and hydration status, urine output and hydration are not specific monitoring needs related to long-term use of carbamazepine (Tegretol).

 CN: Pharmacological and parenteral therapies; CL: Analyze

31. 3. The nurse uses active listening, in which the client's feelings are reflected back to him. Telling the client that everyone wears them does not consider the client's feelings. Telling the client that what he said is not what he meant discounts the validity of his statement. Interpreting the reason for the client being upset as the rule being unreasonable does not take into account how it affects the client personally.

 CN: Psychosocial adaptation;
CL: Synthesize


32. 3. The restraint should remain in position. Removing the restraint or untaping the restraint will risk dislodging the I.V.

 CN: Safety and infection control;
CL: Apply


33. 2, 3, 4. The purposes of the Pap (Papanicolaou) smear include: to detect precancerous and cancerous cells of the cervix; to assess the effects of sex hormonal replacement; to identify viral, fungal, and parasitic conditions; and to evaluate the response to chemotherapy or radiation therapy to the cervix.

 CN: Health promotion and maintenance;
CL: Apply

34. 2, 3. The nurse should use at least two sources of identification before administering medication to any client. The identification can include the medical record number and the client's date of birth. It is not necessary to check the client and dose for this drug with another nurse. It is also not safe to use the room number or bed number as a source of identification as clients' locations in the hospital are frequently changed. The nurse should not assume that the child will give a correct first name.

 CN: Safety and infection control;
CL: Apply

35. 2. One of the actions of propranolol (Inderal), a drug used in the treatment of migraine headaches, is to decrease the heart rate. The nurse should assess the client's blood pressure to evaluate overall circulatory response to the medication. Until the blood pressure value is assessed, there is no immediate need to contact the physician. The nurse should complete the blood pressure assessment before administering the drug. There is no immediate need to administer oxygen or contact a relative because a slowed pulse rate is an expected action of propranolol.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

36. 1. During the tertiary circular reaction stage of the sensorimotor stage (12 to 18 months of age), the infant comes to understand causality and object performance, recognizing that objects placed out of sight continue to exist. During the preoperational stage (ages 2 to 6), the child's perception is based on how he views an event. The concrete operational stage (ages 6 to 12) is the beginning of concrete, logical thinking. During the formal operations stage (ages 13 to 18), the child is able to perform abstract reasoning.

 CN: Health promotion and maintenance;
CL: Analyze

37. 2. The neonate will be simultaneously dried and stimulated to cry immediately upon delivery. If the neonate does not cry as a result of these measures, the ABCs (airway, breathing, and circulation) of cardiopulmonary resuscitation will be followed. Positioning the neonate and suctioning or clearing the airway ensure that the airway is clear so that the

first breath the neonate takes is air, rather than fluid or particulate matter. Breathing will be stimulated once the airway is clear and then heart rate will be validated either apically or through the cord. The cord may be cut in order to hand the neonate to the mother for nursing. In many instances, the infant is placed on the mother's abdomen before the cord is cut.

 CN: Health promotion and maintenance;
CL: Evaluate

38. 2 mg/minute

First, calculate the concentration of mg/mL:


$$\frac{4}{\frac{1,000 \text{ mg}}{250 \text{ mL}}} = 4 \text{ mg/mL}$$

Next, multiply the number of milligrams per milliliter by the pump setting in milliliters per hour:


$$\frac{4 \text{ mg}}{1 \text{ mL}} \times \frac{30 \text{ mL}}{1 \text{ hour}} = 120 \text{ mg/hour}$$

Next, divide the milligrams per hour by 60 to obtain milligrams per minute:


$$120 \text{ mg/hour} \div 60 \text{ minutes} = 2 \text{ mg/minute}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


39. 1. The client may become tolerant of the antianginal effects of nitrates. Removing nitrates for 8 hours each day is usually effective in preventing tolerance. Nitrate patches should not be used on an as-needed basis. Sites should be rotated daily to prevent skin irritation, but this is not related to tolerance. Removing the patch for only 8 hours is sufficient to prevent tolerance and skipping days could impact the drug's effectiveness.

 CN: Pharmacological and parenteral therapies; CL: Apply

40. 2. The nurse should tell the client in a simple, matter-of-fact manner the purpose of the restraints to help the client understand why restraints are necessary. Long explanations and interactions with the acutely manic and agitated client are not appropriate or therapeutic at this time because the client with a high level of anxiety has difficulty focusing and processing. Saying "threatening others and throwing furniture is not allowed" could lead the client to believe he is being punished. Reminding the client that he's "been here before and knows what the rules are" and "we are only doing this for your own good, so calm down" are condescending and verbalizing the expectation that he can control his illness.

 CN: Psychosocial adaptation;
CL: Synthesize


41. 1,2, 3 5. Anorexia or loss of appetite is not associated with valproic acid. Adverse effects include tremors, transient hair loss, gastrointestinal upset, and weight gain.

 CN: Pharmacological and parenteral therapies; CL: Analyze


42. 3. Intercourse commonly stimulates uterine contractions. The prostaglandins found in semen can also initiate contractions. After placement of a cerclage for advanced dilation and contractions, the client is considered at high risk for preterm delivery and should be seen by her health care provider more frequently. The client should call the health care provider immediately if she sees signs of complications, such as leaking fluid (rupture of membranes), vaginal bleeding, and contractions (particularly with a cerclage in place). Anything in the vagina may initiate contractions and the labor process.

 CN: Reduction of risk potential;
CL: Evaluate


43. 2. A prolonged QT interval is significant because it can lead to the development of polymorphic ventricular tachycardia, also known as *torsades de pointes*. A prolonged QT interval may result from electrolyte imbalance but it does not lead to the development of an electrolyte imbalance, atrial fibrillation, or orthostatic hypotension.

 CN: Physiological adaptation;
CL: Analyze

44. 1. The nurse should instruct the mother to bring the child to the emergency department. If aspirated, nuts may swell leading to an airway obstruction after the initial event; endoscopy may be required to remove remaining fragments. Bleeding from trauma to internal organs after abdominal thrusts is rare. There are no signs of shock to suggest anaphylaxis. There is no indication of the presence of a pneumothorax.

 CN: Physiological adaptation;
CL: Synthesize

45. 1. Gastric upset is an adverse effect of NSAIDs. Taking these drugs with food and fluids minimizes this effect. The dosage of NSAIDs does not need to be tapered. Because NSAIDs do not cause drowsiness or stomatitis, the client does not need to restrict driving or rinse the mouth.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

46. 2. The neonate's Apgar score has been improving since birth. (The birth score is 6; the current score is 9.) The nurse should continue to assess the neonate. There is no indication that oxygen is


needed since the color is improving, and stimulating the baby is not necessary as the he is now flexing his extremities.

 CN: Management of care;
CL: Synthesize


47. 2. Today's health care network includes many specialized areas, such as respiratory therapy, medicine, laboratory, social services, and technical monitoring, to name a few. Due to expanded media coverage of health care issues, parents are more aware of health care issues but cannot understand all the ramifications of possible health care decisions. Because of this expanded media coverage, health care consumers are more aware of advances in the science of health care. Nurses have always recognized the value of communication and that all nurses are teachers. Clients are more aware of their rights through media exposure and information disseminated by health care facilities. However, respect for the client's rights should be the nurse's concern as well and communicating with parents and children should not be impacted by a client's knowledge or demand for those rights.

 CN: Health promotion and maintenance;
CL: Apply

48. 4. Soft, washable toys are appropriate for infants, who tend to place everything in their mouths. These toys are not harmful. Plastic toys cannot be manipulated by a child of this age and the child would put the car in his mouth, which may not be safe due to small parts that may be swallowed or aspirated. Games and puzzles are too advanced for a 5-month-old and he could put the pieces in his mouth and swallow them. Some stuffed animals have eyes that can be swallowed or aspirated.


 CN: Reduction of risk potential;
CL: Apply

49. 1. The oxygen levels for this neonate have dropped during the last 8 hours; the nurse should administer oxygen, as the neonate is not obtaining adequate oxygenation on room air. The recommended pulse oximetry reading in a term neonate is 95% to 100%. Keeping the neonate warm may improve the oxygen saturation if that is the cause of the poor gas exchange, but overheating with warm blankets may increase oxygen demand. Waiting to reassess the neonate could cause the neonate to have inadequate oxygen levels unnecessarily. While blood gases may be drawn, the first action is to administer the oxygen.


 CN: Management of care;
CL: Synthesize

50. 3. The nurse should give the next dose as ordered because the blood level is 35 mcg/mL, which is lower than the normal range of 50 to 100 mcg/mL.

Withholding the next dose, notifying the physician, and taking the client's vital signs are not indicated in this situation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


51. 3. Going for a walk with the nurse and another client is a more gradual introduction to being with others. The goal is to gradually encourage interaction with others; playing games in the client's room promotes continued isolation. Going to a group session and participating in crafts is exposing the client to large groups too rapidly.

 CN: Psychosocial adaptation;
CL: Synthesize

52. 4. The client is not emptying her bladder after repeated attempts. The nurse should now use an in-and-out catheter to empty the bladder. While the other comfort measures may be helpful, this client has not completely emptied her bladder since delivery and will be at risk for a urinary tract infection.

 CN: Management of care; CL: Synthesize

53. 4. The signs and symptoms of sepsis in a neonate, such as changes in appearance and behavior, are almost imperceptible. Often, the parents' only complaint is that the neonate does not look "right." Fever and localized response, which are clues to infections in older children, are often absent in the neonate. Telling the father that he should have realized something was wrong is condescending and serves only to further the father's guilt feelings. Asking the father whether he read the booklet from the hospital implies that the father is at fault. One experience would not necessarily ensure that the father would be able to detect sepsis another time.


 CN: Psychosocial adaptation;
CL: Synthesize

54. 3. Nursing bottle caries occur when a child is routinely given a bottle of milk or juice at nap and bedtime. When teeth become coated in sugar before sleep, the lack of activity in the child's mouth for several hours during sleep allows the sugar to convert to acid, leading to decay. A child drinking 18 to 20 oz of whole milk in a day should not be malnourished, although she may lack essential vitamins and iron. Anemia may occur if she is only drinking milk because it contains no iron; however, the mother indicates she is eating meals. Regardless, children of this age should be taking no more than 16 oz of milk per day, and most children at this age should be drinking from a cup. The mother should be instructed to wean the child to a cup one feeding at a time until the child is completely weaned to a cup for all feedings. The last bottle-feeding to be replaced is usually the night bottle. Malocclusion of


the teeth does not occur at 15 months. If the child were to continue to suck on a bottle until age 4 years or later, then malocclusion may occur.

 CN: Psychosocial adaptation; CL: Apply


55. 4. Safety standards require the use of two identifiers prior to medication administration. A parent can be used as the second identifier. Many young children will only answer to a nickname that does not coincide with the medical identification band, or may answer to any name. It is common for children on a pediatric floor to go into each other's rooms. A small child may not know their birth date.

 CN: Safety and infection control;
CL: Apply


56. 2. The primary reason to give a diuretic to a client with heart failure is to promote sodium and water excretion through the kidneys. As a result, the excessive body water that tends to accumulate in a client with heart failure is eliminated, which causes the client to lose weight. Monitoring the client's weight daily helps evaluate the effectiveness of diuretic therapy. The client should be advised to weigh herself daily. An increased appetite or decreased thirst does not establish the effectiveness of the diuretic therapy, nor does having clearer urine after starting torsemide.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


57. 3. The client should be placed in a side-lying position and encouraged to take a deep breath during the insertion of the suppository. Placing the suppository along the rectal wall promotes absorption of the medication and helps avoid placing it into a stool mass. The nurse should insert the suppository 3 to 4 inches into the rectum of an adult client.

 CN: Reduction of risk potential;
CL: Apply


58. 4. The nurse is wearing protective personnel equipment appropriately for suctioning the client: goggles, gown and respirator mask. It is not necessary to wear a powered air purifying respirator face shield to suction a tracheostomy. A surgical mask does not provide maximum protection.

 CN: Safety and infection control;
CL: Apply


59. 2, 3, 5, 6. Safety and physiological needs are crucial initially for a client who is unable to meet her own needs. Identifying her stressors and feelings will be important later when she is responding to questions and her environment.

 CN: Psychosocial adaptation;
CL: Synthesize


60. 4. In most agencies, it is a policy to discard the autologous blood after 4 hours of transfusing, due to an increased risk of infection. Increasing the infusion rate could cause fluid overload. Monitoring blood transfusions is a serious nursing responsibility, and because it is the change of shift, there is increased risk of error.

 CN: Safety and infection control;
CL: Synthesize


61. 1. The client is demonstrating signs of anemia. Beef, beets, and cabbage are good sources of iron. Chicken, dumplings, biscuits, fish, applesauce, jelly, and wine are not major iron sources.

 CN: Health promotion and maintenance;
CL: Synthesize

62. 2. Infants are obligatory nose breathers except when crying. The observation that the infant has slight cyanosis when quiet but becomes pink when crying and the inability to pass a catheter through the left nostril suggest that the neonate is exhibiting symptoms of unilateral choanal atresia. With this condition, one of the nasal passages is blocked by an abnormality of the septum. Surgical intervention is necessary to open the nostril. Typically, a neonate with esophageal reflux disorder exhibits episodes of apnea and vomiting after eating. Respiratory distress syndrome commonly occurs in preterm neonates who lack surfactant to maintain lung expansion. Common findings include sternal retractions, tachypnea, grunting respirations, nasal flaring, cyanosis, pallor, hypotonia, and bradycardia. A neonate with tracheoesophageal fistula commonly exhibits cyanosis during feedings and vomiting.


 CN: Reduction of risk potential;
CL: Analyze

63. 1, 2, 3, 5. Safety measures for poisonous substances include close supervision of children, safely storing toxic substances, teaching proper dosages and differences between adult and child doses, and the proper way to contact the Poison Control Center for instructions. Poison Control should be notified as soon as the poisoning has occurred and airway and circulation have been assessed. Poison Control will direct any further treatment. Syrup of ipecac is rarely used today in the treatment of ingested substances due to the potential for aspiration. It is contraindicated in cases of arsenic poisoning, seizures, and the ingestion of petroleum or corrosive substances.

 CN: Safety and infection control;
CL: Create

64. 4. Dystonic adverse effects of haloperidol, especially oculogyric crises, are painful and frightening. I.M. benztropine is the fastest and most


effective drug for managing dystonia. Lorazepam is an antianxiety medication and is not effective for treatment of dystonia. Although amantadine and diphenhydramine can be used for extrapyramidal symptoms, oral medications do not work as quickly, and amantadine may worsen psychotic symptoms.

 CN: Psychosocial adaptation;
CL: Synthesize

65. 1. Neonates burn brown adipose tissue (fat) as a response to cold stress. In addition, there is increased utilization of glycogen and calorie stores. Hypoglycemia may result from becoming stressed by a cold environment. Neonates do not have the ability to shiver.

 CN: Health promotion and maintenance;
CL: Apply

66. 1. While the adolescent is denying pain, he is displaying objective signs of pain. Adults of Asian ethnicity typically display stoic behavior and the 16-year-old most likely would try to conform to this cultural norm. The nurse should administer an analgesic and assure the client that taking medication will speed the recovery process. The nurse must also reassess the client after administering the pain medication and document the response. The reassessment is typically done 30 minutes after a parenteral analgesic and an hour after an oral analgesic. People who identify with the Asian culture infrequently complain and, therefore, asking the client about what is troubling him is unlikely to provide the nurse with additional information. The adolescent's behavior is consistent with post-operative pain. If the parents are stoic, discussing the adolescent's behavior may be not be productive. At this stage of treatment, distractions can be used in conjunction with medication, but should not be substituted for them.


 CN: Basic care and comfort;
CL: Synthesize

67. 1. Formula should fill the entire nipple of the bottle while the baby is sucking. This decreases the amount of air taken in by the baby; taking in too much air can lead to regurgitation. Not all babies at term are born with well-developed sucking skills. Some neonates are sleepy and do not suck well. For the first feeding, the baby should be bubbled after taking one-fourth to one-half ounce of formula and then again when the infant has finished the feeding. Bottle propping can lead to aspiration, decreased infant bonding, and aspiration of formula. However, it is not associated with the intake of too much air.

 CN: Health promotion and maintenance;
CL: Synthesize

68. 1, 4, 5. When a client complains of back pain with administration of blood, the nurse should suspect a hemolytic reaction, and the blood transfusion

should be stopped immediately. The nurse should prepare for a reaction from mild to severe, including the need for cardiopulmonary resuscitation, because even a small amount of mismatched blood can lead to a major reaction. The nurse should obtain a urine specimen to send to the laboratory to check for hemoglobin because RBC hemolysis filters through the kidneys from the reaction. The nurse should stop the I.V. line with the Y-tubing for the blood and not flush the line with saline so that the client does not receive any more blood. The tubing should be changed so that a tube without blood can be used for infusions. The nurse should anchor an indwelling urinary catheter to monitor hourly urine output.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

69. 2. At 4 hours postpartum, the fundus should be midline and at the level of the umbilicus. Whenever the placenta is manually removed after delivery, there is a possibility that all of the placenta has not been removed. Sometimes small pieces of the placenta are retained, a common cause of late postpartum hemorrhage. The client is exhibiting signs and symptoms associated with retained placental fragments. The client will continue to bleed until the fragments are expelled. Perineal and cervical lacerations are characterized by bright red bleeding and a firmly contracted fundus at the level that is expected. Urine retention is characterized by a full bladder, which can be observed by a bulge or fullness just above the symphysis pubis. Also, the client's fundus would be deviated to one side and boggy to the touch.

 CN: Reduction of risk potential;
CL: Analyze


70. 3. A neonate born at 37 weeks' gestation will have some cartilage in the ear lobes, fine and fuzzy hair, scant to moderate rugae in the scrotum, and a breast nodule diameter of 4 mm. Neonates born before 36 weeks' gestation will have only an anterior transverse crease on the soles of the feet. Extensive rugae on the scrotum are a typical finding in neonates born at 39 weeks' gestation or later. Coarse and silky scalp hair typically is found in neonates that are born at 39 weeks or later.

 CN: Health promotion and maintenance;
CL: Analyze


71. 1, 3, 4. Clear communication is crucial for a client with delirium. The family must include the client in all conversations and keep him oriented to time and place. It is inappropriate to argue with a client's hallucinations because they are real to the client. Speaking more loudly will not help this client hear more distinctly and may increase his confusion.

 CN: Management of care; CL: Synthesize

72. 2. One-to-one supervision provides safety until appropriate detoxification can be given. Restraints are the last intervention after less restrictive alternatives have been tried. It is unlikely that the client can cooperate with staying in a chair. Putting the client in bed in his room puts him at risk for falling and a closed door prevents close observation.

 CN: Safety and infection control;
CL: Synthesize

73. 1. The nurse should recognize that the client's clinical manifestations indicate fluid overload, and decrease the infusion rate so the client's circulation can handle the extra fluid. Antihistamines are used for allergic reactions. The nurse should place the client in an upright position with his feet down so that blood or fluid volume can drain to his lower extremities and relieve some of the extra fluid load on his heart. The nurse does not need to replace the blood with another type of fluid because the client's response is not a blood transfusion reaction.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

74.

2. Place the client in the supine position.

3. Record the highest systolic blood pressure readings in both arms.

1. Place a Doppler probe at a 45-degree angle to the correct pulse (dorsalis pedis or posterior tibial).

4. Record the ankle systolic blood pressure reading when the Doppler sound returns.

The nurse should first place the client in a supine position. Next the nurse should assess blood pressures in both arms and record the highest systolic blood pressure as the brachial pressure. To obtain the brachial pressure, the nurse should place the blood pressure cuff around the affected leg just above the malleolus and then place a Doppler probe at a 45-degree angle to the dorsalis pedis or posterior tibial pulse. The nurse should then inflate the blood pressure cuff until the Doppler sound stops and then deflate it until the Doppler sound returns. The point when sound returns is recorded as the ankle systolic pressure. The ankle-brachial index is the ankle (dorsalis pedis or posterior tibial) pressure divided by the highest arm pressure. A pressure above .90 is normal; anything lower indicates obstruction.

 CN: Physiological adaptation;
CL: Synthesize


75. 2. Insensible fluid loss is invisible vaporization from the lungs and skin, and assists in regulating body temperature. The amount of water loss is increased by accelerated body metabolism, which occurs with increased body temperature. The client's body mass index does not directly influence calculating fluid therapy. When the client's last meal was consumed and the availability of I.V. fluids have no influence on the analysis of intake and output.

 CN: Management of care; CL: Analyze

76. 3. A toddler has not developed the concept of sharing, so two similar toys must be provided to prevent disagreements. Playing together in harmony is not the developmental level of a toddler. They play side by side, but not together. Threatening to put the children in their rooms does not solve the problem, nor does taking away the toy.

 CN: Health promotion and maintenance;
CL: Synthesize

77. 2. In order to reestablish trust, the nurse should first try to determine if something happened at the last visit that was upsetting for the family. Dislocation of a body part can be seen as a source of illness among persons of Mexican ethnicity. At a well-child visit the health care provider would have palpated the fontanel. If it is now sunken from dehydration, the parents may blame the provider for the illness. This belief is referred to as *Caida de la mollera*. The family may have talked with a traditional healer, but following this line of questioning first may appear that the nurse considers the healer as an adversary. Asking about immigration makes a stereotypical assumption. Asking if the family is afraid the baby will be taken from them may be suggesting something the family has never considered and may cause unnecessary distress.

 CN: Psychosocial adaptation;
CL: Synthesize

78. 1. The child wants attention from the nurse, even if the behavior is met by a negative response. Aggression, resistance against authority, and exaggerated stress are behaviors that can be associated with a 4-year-old. However, coming to the nurses' station after being told not to do so is not an example of these behaviors.

 CN: Psychosocial adaptation; CL: Analyze

79. 1, 2, 3. Clinical manifestations of dehydration include decreased tearing; dry mucous membranes; sunken fontanelles; weight loss; behavioral changes; scanty, concentrated urine; and a thready, fast pulse. Clear, pale yellow urine would indicate adequate hydration. A bounding pulse would indicate fluid volume excess.

 CN: Physiological adaptation; CL: Analyze

80. 3. When a neonate is being transferred to a neonatal care center (level III nursery), the parents should be allowed to see and touch the neonate, if possible, before transfer. The parents should be given the location and telephone number of the unit to which the neonate is being transferred. This helps to keep the parents informed. The parents are already aware of the neonate's condition and should recognize that it is critical if the neonate is being transferred to a neonatal care center. The parents have signed consent for treatment on admission, and in most states another consent is not necessary. Asking whether the father would like to ride in the ambulance with the neonate during the transfer is inappropriate. Most ambulances or transferring vehicles (e.g., helicopters, airplanes) do not allow family members to accompany the ill client. Space in the motor vehicle, helicopter, or plane is limited. In addition, most transferring vehicles do not have insurance to cover family members should an accident occur during transfer.

 CN: Management of care; CL: Synthesize

81. 4. Tenets of the Roman Catholic Church hold that it is acceptable for anyone, regardless of religious belief, to baptize a neonate. For Roman Catholic families, baptism ensures entry into heaven. Local practice may vary, and in some situations the parents may prefer to have a Roman Catholic person perform the rites; however, this person may not be available until after the death. The parents may wish to have a priest contacted for grief support. Notification of the hospital's director is not necessary.

 CN: Management of care; CL: Synthesize

82. 1. Moist heat is a nonpharmacologic pain management strategy that may alleviate pain and reduce the dose of analgesic, if required. Heat dilates blood vessels, and decreases inflammation. Lifting and circular exercises will aggravate the already-inflamed joint. Cold constricts blood vessels, and dry ice is not used on the body.

 CN: Basic care and comfort; CL: Evaluate

83. 3. For a lumbar puncture (LP), a needle is inserted into the subarachnoid space to obtain a specimen of spinal fluid for diagnostic testing. Fluid on the lumbar dressing indicates cerebrospinal fluid (CSF) leakage, and must be reported to the physician immediately. The client should be encouraged to drink fluids after an LP to facilitate production of CSF. It is normal to have a mild headache due to the removal of CSF samples for laboratory analysis. Although the concerns of the client should be discussed with the physician at some point, the CSF leakage is a priority and should be reported immediately.

 CN: Reduction of risk potential;
CL: Analyze


84. 3. The normal calcium level is 9.0 to 10.5 mg/dL. Hypercalcemia is commonly seen with malignant disease and metastases. The other laboratory values are normal. Hypercalcemia can be treated with fluids, furosemide (Lasix), or administration of calcitonin. Failure to treat hypercalcemia can cause muscle weakness, changes in level of consciousness, nausea, vomiting, abdominal pain, and dehydration. Although the client is on hospice care, she will still need palliative treatment. Comfort and risk reduction are components of hospice care.

 CN: Reduction of risk potential;
CL: Synthesize

85. 2. The LPN should report a maternal pulse rate of 100 bpm at rest because it could potentially indicate shock or hemorrhage. Typically, the pulse rate of a postpartum client slows after delivery and continues to be slow for about 1 week because of an increase in central circulation that results in increased stroke volume to provide adequate maternal circulation. The normal pulse rate is 60 to 70 bpm. Neonatal regurgitation of 1 tablespoon after a feeding, a neonatal heart rate of 140 bpm at rest, and increased maternal lochia rubra when the mother initially ambulates are normal findings.

 CN: Management of care; CL: Analyze

86. 2. A child with a cardiac defect finds that squatting decreases venous return and workload to the heart and increases comfort and blood flow to the lungs. Squatting traps blood in the lower extremities so less blood is returned to the right atrium. Squatting does not make it easier for the child to play with toys. Squatting does not relieve abdominal pressure; it may even increase it slightly. Squatting has no effect on muscle tone. When done by a child with a cardiac defect, it is not meant as an exercise but is a compensatory process used to reduce dyspnea.

 CN: Physiological adaptation;
CL: Evaluate

87. 3. The diaphragm is the major muscle of respiration; it is made up of two hemidiaphragms, each innervated by the right and left phrenic nerves. Injury to the phrenic nerve results in hemidiaphragm paralysis on the side of the injury and an ineffective breathing pattern. Consciousness, cardiac function, and urinary elimination are not affected by the phrenic nerve.

 CN: Management of care; CL: Analyze

88. 2, 3, 5. Tay-Sachs disease is associated with a particular cultural background, Eastern European Jewish descent. As an autosomal recessive disease, for an infant to be affected, each parent must carry a recessive trait. If both parents carry the trait, each

offspring has a 25% chance of inheriting the disease, a 50% chance of being a carrier, and a 25% chance of being unaffected. The shape of red blood cells is altered with Sickle Cell Disease rather than cystic fibrosis. Chorionic villi sampling (CVS) testing can identify whether a fetus is or is not affected.

 CN: Health promotion and maintenance;
CL: Create

89.

2. Open the airway.

3. Start an I.V. access site.

1. Call the physician.

4. Explain the situation to the family.

An open airway is essential to survival. The nurse should first ensure an open airway. Next, the nurse should start an I.V. and then notify the physician. Finally, the nurse should inform the family of the situation and, if appropriate, allow them to remain with the client.

 CN: Management of care; CL: Synthesize

90. 1. Prevention of another pulmonary embolus is important; the nurse should teach the client to observe for signs of clot formation to prevent a potentially fatal episode and maintain cardiopulmonary integrity and adequate ventilation and perfusion. Elevation of the lower extremities, not lowering them, promotes venous return to the heart. Ambulation must be done several times each day. Limiting fluid intake increases blood viscosity, promoting clot formation.

 CN: Health promotion and maintenance;
CL: Synthesize


91. 2. When a client is being released from the hospital with her neonate and the nurse learns that the client is homeless, the nurse should contact the hospital's or unit's social worker. Social workers have access to resources to assist the client to find temporary shelter in emergencies. The director of the birthing unit does not need to be notified. The director's responsibilities are primarily administrative. The client's physician can be notified once the social worker has offered assistance to the client. The physician may cancel the release of the neonate until temporary housing is located. Notifying the client's family is inappropriate. The client may not have any immediate family members, or there may be some stress between the client and family.

 CN: Management of care; CL: Synthesize


92. 2, 3. A client who has had numerous surgical or medical procedures is more prone to latex exposure and thus latex sensitivity or allergy. People who are allergic to latex may also have an allergy to fresh fruits and vegetables such as tomatoes. If a client denies a latex allergy, the nurse should ask about food allergies to fresh fruits and vegetables as well as for latex allergies and shellfish for iodine allergies. The client with one allergy commonly has more than one allergy, so the nurse must specifically ask the client about food allergies related to other allergies.

 CN: Reduction of risk potential;
CL: Analyze

93. 4. The teenage girl has scoliosis, the lateral deviation of the spine. Kyphosis is noted by a forward curvature of the shoulders. Arthritis is diagnosed by radiographs. Hip dysplasia is noted in older children by pain, but is usually diagnosed before the child walks by noting excessive gluteal folds and limited hip abduction.

 CN: Health promotion and maintenance;
CL: Analyze

94. 1, 3, 4, 5. The nurse is responsible for the client's safety in the operating room. The nurse should call a time-out if the client is not properly identified with an identification band. In addition, an I.V. line and oxygen should always be established when an ET tube is placed. This practice applies whenever a client's airway is compromised enough for intubation to occur, not only in the operating room environment. An anesthesiologist should be present during surgery to manage the airway. Post-operative pain medication is administered in the recovery room.


 CN: Safety and infection control;
CL: Synthesize

95. 1. Anencephaly is a neural tube defect that is not compatible with life, although some infants with anencephaly live for several days before death occurs. When the client has decided to continue the pregnancy and donate the neonatal organs after the death of the neonate, the nurse should remain nonjudgmental. The nurse should explore his or her feelings about the issue of anencephaly and organ donation. The nurse should not make judgments about the client's position, nor should the nurse try to persuade the client to terminate the pregnancy. Contacting the client's minister to explore the client's options is not appropriate. As a devout Baptist, the client probably has already discussed the matter with her minister. Telling the client that the neonatal death will be prolonged and painful to her is not helpful. Death may occur very soon after birth. Contacting the client's family members is not


appropriate. The client may wish to maintain confidentiality and privacy related to the birth.

 CN: Management of care; CL: Synthesize


96. 2, 3, 4, 5. Anorexia is commonly the first indication of digoxin toxicity. Arrhythmias are also common with digoxin toxicity. Although bradycardia is the most common sign of toxicity, other tachycardic arrhythmias can occur. A normal pulse rate for a 3-month-old child at rest is about 120 bpm. Blurred vision can be associated with digoxin toxicity and may be detected in an infant if he stops following moving objects. Sudden vomiting or drowsiness can be associated with digoxin toxicity. Constipation is not associated with digoxin toxicity and is not an adverse effect of digoxin.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

97. 2. If the specimen was from a fingerstick and not a venous sample, the potassium level can be falsely elevated. Because the finger is squeezed to obtain the sample, cells may have been broken from the pressure of squeezing. When the cells break, they release potassium, which will falsely elevate the potassium level in the result. Calling the physician without first checking the source of the sample would not give the physician accurate and complete information. A cardiac monitor would not be necessary if the potassium level is falsely elevated. The last 24-hour output would only indicate that the infant is voiding in an adequate amount. This may or may not have an influence on the infant's potassium level.


 CN: Reduction of risk potential; CL: Synthesize

98. 3. The level of lethality of a client's suicidal thoughts depends on the presence or absence of a plan. If the client has a plan, the nurse must know what it is and whether or not the client has access to the means to complete suicide. The initiation of suicide precautions is necessary whenever a client threatens suicide, but first it is important to discover more information about what the client is thinking and planning. Unless the client has at his disposal the means to harm himself or is constantly trying to harm himself with objects on the unit, placing him on a suicide watch or confining him to his room are overreactions to the client's disclosure of suicidal ideation.


 CN: Safety and infection control; CL: Synthesize

99. 1, 2, 4. The safest position for a hospital bed is in the low position if the client is not being attended by the nurse. All I.V. rates should be running at the prescribed level or changed to that level. The laboring client should be able to determine who

is with her during the labor process and nursing serves as the advocate for the client if the client wishes to have changes made. Laboring mothers should not be lying flat on their backs as this creates compression of the vena cava and decreases oxygenation to both the mother and the infant at a time when the best perfusion is desired. Pain should be relieved or expressed to be tolerable at any point in the labor process. It is not necessary to use continuous fetal monitoring in the early stages of a low risk pregnancy and labor.

 CN: Safety and infection control; CL: Evaluate

100. 4. Due to the client's psychosis and difficulties coping, a positive, supportive environment is essential to limit further regression and help the client engage in her own treatment. Confrontation and peer pressure are the type of milieu more suited to a chemically dependent client. While involvement in self-governance can be therapeutic, forcing a psychotic client to participate in self-governance before she is ready could actually hinder treatment and recovery. Although group activities are commonly required in treatment programs, a client who is very disturbed or confused is not forced to attend. Also, the client must participate when and how she feels comfortable, rather than mandating a specific amount of participation. Equal participation by clients does not ensure a therapeutic milieu or speed the client's recovery.

 CN: Psychosocial adaptation; CL: Synthesize

101. 4. The nurse should refuse to administer the medication to the client because of the risk of respiratory depression in the neonate. Meperidine, given I.M., peaks in 30 to 60 minutes and lasts 2 to 4 hours. Based on the assessment findings, the client most likely will be delivering within that time frame, increasing the risk of respiratory depression in the neonate, a serious consequence. Therefore, the nurse should not administer the drug. Naloxone (Narcan) should be readily available whenever opioids that can result in respiratory depression are used. Asking the physician to validate the dosage is not necessary. For clients in early labor, meperidine can be given I.M. in dosages ranging from 50 to 100 mg.

 CN: Management of care; CL: Synthesize

102. 2. Bending the chin down toward the chest decreases the risk of food entering the trachea and causing aspiration into the lungs. The client should sit up at a 90-degree angle when eating. Although eating and talking increase the risk of aspiration as well as muscle fatigue, the nurse should encourage the client to have visitors but avoid talking while chewing and swallowing. The client should rest

before eating because muscle fatigue can contribute to choking.

 CN: Reduction of risk potential;
CL: Synthesize

103. 42.3 mm Hg

To obtain CPP, use this formula:

CPP = mean arterial pressure (MAP) – ICP.

To obtain the MAP, use this formula:

$$\text{MAP} = [\text{systolic BP} + (2 \times \text{diastolic BP})] \div 3$$

$$\text{MAP} = [90 + (2 \times 50)] \div 3 = 63.3$$

$$\text{CPP} = 63.3 - 21 = 42.3 \text{ mm Hg.}$$

 CN: Physiological adaptation; CL: Apply

104. 1. The client with a spinal cord injury above T6 who suddenly experiences clinical manifestations of autonomic stimulation, such as flushing, sweating, and piloerector muscle contraction, is demonstrating life-threatening autonomic dysreflexia. The cluster of manifestation results from noxious stimuli, such as a full bladder, or lying on a foreign object, such as a plastic cap or crinkled paper, which the client cannot feel. As soon as the noxious stimulus is removed, the manifestations begin to subside. When the client demonstrates clinical manifestations of autonomic dysreflexia, the nurse should first elevate the head of the bed immediately to decrease the intracerebral pressure caused by the hypertension that developed from autonomic stimulation. The nurse can next check for a distended bladder or foreign object. The client's blood pressure will be elevated; the nurse should assess vital signs frequently.


 CN: Management of care; CL: Synthesize

105. 3. The nurse should refer the client to a social worker for assistance in enrolling in the WIC program. This program provides assistance for foods such as milk, cereal, and infant formula. Instructing the client in low-cost, highly nutritious meal preparation will not meet the client's need for additional funds for food. Determining whether the client qualifies for state assistance is part of the role of the social worker, not the nurse. Asking the client if she has a job and the amount of income earned is not within the role of the nurse. The social worker can determine whether the family income guidelines are met for state and federal assistance.

 CN: Management of care; CL: Synthesize

106. 4. Telling the client about one activity at a time with 10 minutes' notice gives the client time to prepare for that activity. Writing out the schedule does not ensure that the client will remember to look at it. It is overwhelming to explain an entire day's schedule all at once to a client diagnosed with


dementia. Leading a client to an activity after the fact doesn't allow the client to prepare.

 CN: Psychosocial adaptation;
CL: Synthesize

107. 1, 2, 3, 4. Safety of others is a priority and the nurse must monitor the client's anger and potential for aggression. The nurse should also find safe ways for the client to express his anger and any other feelings about the abuse. A referral to a support group is appropriate because anger management groups are one way to assist the client in learning to manage anger. Nothing about jail is mentioned in the question. Discussion of jail does not help the client address his issues with anger and the abuse causing the anger.

 CN: Management of care; CL: Synthesize

108. 2. The primiparous client at 2 hours postpartum who delivered a term neonate vaginally should be assessed first because this client is at risk for postpartum hemorrhage. Early postpartum hemorrhage typically occurs during the first 24 hours postpartum. Once the nurse has assessed the client's fundus, lochia, and vital signs, a determination about the stability of the client can be made. After this assessment, the nurse can provide care to the other clients, who are of lesser priority than the newly delivered primiparous client.

 CN: Management of care;
CL: Synthesize


109. 1. Legionellosis is a pneumonia caused by the bacterium *Legionella pneumophila* that thrives in water that is 95° to 115° F (35° to 46° C). When a building's hot water plumbing has water at this temperature, the bacteria thrive; then they may be transmitted via inhalation from air conditioning, showers, spas, and whirlpools. The bacteria are not transmitted via smoke or ceiling fan blades or by swallowing contaminated water.

 CN: Health promotion and maintenance;
CL: Synthesize


110. 2, 3. The client should be instructed not to eat or drink for 8 to 12 hours before the test. Stools will be white for up to 72 hours following the procedure as the barium is eliminated from the body. Laxatives and fluids will be encouraged after the procedure to help prevent barium impaction, but the client will not be given stool softeners or laxatives before the procedure. The client should not experience pain during the procedure. The nurse should also instruct the client to stop smoking at midnight the night before the test.

 CN: Reduction of risk potential;
CL: Apply


111. 3, 4. A National Patient Safety Goal of The Joint Commission is to improve the accuracy of client identification; to attain that goal, health care personnel must use at least two client identifiers when providing care, treatment, or services. The medical record number and name as printed on the client's name band are appropriate identifiers. Because the client can change rooms and beds, these are not to be used as identifiers. Social security number is not used as an identifier for health care or treatment purposes.

 CN: Safety and infection control;
CL: Apply


112. 4. There is no cure for metastatic cancer of the liver; palliative nursing care is required. Liver transplants are not recommended for the client with widespread malignant disease. Prescribed medications will not make metastatic lesions shrink. There is nothing to indicate that the client is receiving chemotherapy; therefore, explaining its effects would not be helpful.

 CN: Physiological adaptation;
CL: Synthesize


113. 3. The vastus lateralis site is the preferred I.M. site for all ages because it does not have any major nerves or blood vessels located near it. The deltoid and dorsogluteal muscles have major nerves and blood vessels located nearby. The triceps is not an acceptable muscle for I.M. injections because it is not well developed in most clients.

 CN: Pharmacological and parenteral therapies; CL: Apply


114. 1. Clients should be instructed to rinse their mouths after using a steroid inhaler to avoid developing thrush. Clients should also be instructed to inhale slowly through the mouth and then hold the breath as they count to 10 slowly. It is not necessary for the client to cough and deep-breathe before using the inhaler.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


115. 2. The nurse should stay with the client during the first 15 minutes of a blood transfusion because this is when reactions are most likely to occur. Blood products should never be refrigerated on the nursing unit. Blood that has not been infused after 4 hours should not be infused. The blood should be infused over the specific time ordered by the physician. If a fever develops, the transfusion should be stopped immediately and the blood reaction policy of the facility should be followed.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


116. 2. The symptoms of difficulty breathing, elevated blood pressure, and cough are indicative of circulatory overload. Circulatory overload occurs when blood is infused more rapidly than the circulatory system can accommodate. Anaphylactic reactions are manifested by urticaria, wheezing, and shock. Sepsis begins with a rapid onset of chills and fever. Acute hemolytic reaction is typically manifested by chills, fever, low back pain, and flushing.

 CN: Pharmacological and parenteral therapies; CL: Analyze

117. 2. Sucralfate (Carafate) should be taken on an empty stomach 1 hour before or 2 hours after meals, and at bedtime. It is usually taken four times a day. There is no need to avoid milk products while taking the drug. Sucralfate does not affect hemoglobin levels.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


118. 1. Anger is a common feeling that may lead to self-mutilation. Anger must be expressed in safe ways to diminish self-mutilation. Confronting the abusers directly is rarely successful and must be done with much preparation. Talking about the abuse typically decreases, not increases, self-mutilation. Civil suits are possible, but should only be undertaken after significant recovery from the abuse.

 CN: Psychosocial adaptation;
CL: Synthesize


119. 1, 2, 3, 4. The client with conjunctivitis can use warm soaks to remove crusting. The nurse should teach the client to dispose of the soaks by wrapping them in a separate bag to avoid spreading bacteria. Topical antibiotics are used to treat the infection. The client should avoid contaminating the tip of the medication dispenser. Bacterial conjunctivitis requires containing the spread of the infection. The client should wash his hands after touching his eyes, but he does not need to be isolated.

 CN: Reduction of risk potential;
CL: Create


120. 2, 5. Two sources of identification must be confirmed before administering medication to a client. A source of information can be the client's record number, name, or date of birth, as noted on the client's armband. A client may be confused or hard of hearing and may give a wrong name or answer to a wrong name, thus having the client state his name or respond to his name is not safe practice. Client recognition is not sufficient identification for administering medication. Clients change rooms frequently, so a room number is not a source of identification for administering medication.

 CN: Pharmacological and parenteral therapies; CL: Apply


121. 2. Children who witness domestic violence commonly grow up to be victims or abusers. Counseling helps interrupt the pattern of violence in families. Limiting contact between the father and child does not address the child's behavior, and outgrowing violent behaviors is not likely without other interventions. Setting limits on violent behaviors alone does not address the child's feelings and needs.

 CN: Psychosocial adaptation;
CL: Synthesize

122. 2, 3. A National Patient Safety Goal of The Joint Commission is to improve the effectiveness of communication among caregivers. The requirement for verbal or telephone orders, or for telephonic reporting of critical test results, is to verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. Effective communication which is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved client safety. "Read-back" procedures are not intended to discourage or prohibit telephone communications among health care providers or to promote use of electronic medical records. Safety procedures, such as provider identification codes, are in place for health care providers to give verbal or telephone orders.

 CN: Safety and infection control;
CL: Apply


123. 2. After such a crime, talking about his memories and feelings is an early part of the emotional recovery process. Encouraging him to talk to the FBI and helping him prepare for the trial may be appropriate later as he reorganizes his life for a trial. It is important for him to express his anger, even fantasies of revenge, rather than repress it.

 CN: Psychosocial adaptation;
CL: Synthesize


124. 4. The nurse should allow the client to see and hold the baby for as long as she desires. Such activities provide memories for the mother and assist in the grieving process. There is a possibility that the client may change her mind about the adoption. In most states, there is a defined period (6 months to 1 year or longer) before an adoption becomes final. If the client changes her mind about the adoption, the nurse should accept the client's decision and notify the physician and social worker. Telling the client that it would be best if she didn't see the baby is imposing the nurse's value system on the client. Allowing the client to see the baby through the nursery window is inappropriate because the client should be allowed to touch and hold the baby. Contacting the physician for advice related to the client's visitation is not necessary.

 CN: Management of care; CL: Synthesize


125. 2. A decrease or change in the level of consciousness is an early indication of increased intracranial pressure (ICP) and should be reported to the child's physician as soon as possible to try and control the pressure so it doesn't increase further. Vomiting can be a sign of increased ICP that occurs with a brain tumor, but it usually occurs unrelated to food and in the morning upon arising. Blood pressure increases with a brain tumor due to pressure on the brain stem. Concentrated urine is a sign of dehydration and is not related to the signs of a brain tumor.

 CN: Physiological adaptation;
CL: Analyze

126. 4. With a severe gonorrheal infection, scarring of the fallopian tubes may occur, and becoming pregnant may be difficult or impossible. If the girl's partner is not treated, she can be reinfected. There is no immunity against gonorrhea and, if exposed again, the girl can again become infected. Although a condom may provide some protection against contracting gonorrhea, it is not an adequate protection against the condition and will not help clear up an existing infection. It is only with proper antibiotic administration that the condition can be eradicated.

 CN: Safety and infection control;
CL: Evaluate

127. 1, 2, 3, 4. The goal of "medication reconciliation" is to ensure that clients are on the right medication after any transfer, admission, or going in and out of a health care facility. It is not necessary to reconcile the medications if the client moves to a different room on the same floor. It is estimated that more than half of medication errors occur during these transitions, and medication reconciliation can reduce errors by 70% or more. The Joint Commission requirements mandate medication reconciliation programs.

 CN: Pharmacological and parenteral therapies; CL: Apply

128. 1. Acute poststreptococcal glomerulonephritis usually follows a streptococcal throat or skin infection by 1 to 2 weeks. Streptococcus-type infections require medical intervention with antibiotics. Antibacterial mouthwashes do not kill streptococci. Previously prescribed antibiotics may not be effective against streptococci, and may also be expired. Bar soap fragrance has no impact on its ability to kill bacteria that reside on skin.

 CN: Health promotion and maintenance;
CL: Synthesize

129. 1. To be a true client advocate, the nurse should ask the client if she desires an epidural anesthetic even though the client has indicated a desire for "natural childbirth." The client has a


right to change her mind and also a right to refuse treatment. The client, not the nurse, should be the one to tell the physician that she does not want an epidural anesthetic; the nurse should support the client's decision. Although telling the client that her labor will be more comfortable with an anesthetic provides the client with information, a statement such as this can be viewed as an attempt to change the client's mind. The client may wish to discuss this situation with her husband, but she does not have to do so.

 CN: Management of care; CL: Synthesize


130. 2, 3. In order to meet the criteria for discharge from same-day surgery, the postoperative client must be able to take fluids by mouth, walk without hypotension, void, and be escorted by a responsible adult who will drive him home. Transportation home via a taxicab is not a sufficient escort to assist a client home after surgery. The client may be discharged with severe pain. The nurse should make sure the client has a prescription for pain medication. Because a client has been on nothing-by-mouth status and thinks he is dry is not a sufficient reason for being unable to urinate postoperatively. The inability to void in the first 8 hours after surgery is one of the potential complications for all surgical clients and is related to the stress response.

 CN: Safety and infection control;
CL: Evaluate

131. 1. Eyedrops are correctly instilled by placing them in the lower conjunctival sac. Eyedrops should not be placed near the lacrimal ducts, to decrease the chance of the medication's being systemically absorbed. Placing the drops on the cornea or sclera is uncomfortable for the client and may cause the medication to run out of the eye socket instead of being absorbed.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

132. 4. To treat anaphylactic reactions, epinephrine is administered to counteract the effects of histamine. Epinephrine is a rapid-acting sympathomimetic drug that has a bronchodilator effect. Dopamine may be used if hypotension develops. Diphenhydramine may also be given, but not as the initial drug of choice. Cimetidine is not administered to treat an anaphylactic reaction resulting in shortness of breath.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

133. 1, 2, 3, 4. Benchmarking is a technique for learning from the success of others in an area where care improvement is desired by comparing the data from others with the data about the nursing problem for which improvement is sought. Sources

of information for benchmarking include: literature reviews, databases, unions, standard-setting organizations, local organizations, universities, the government, staff or customer interviews, and questionnaires. A recommendation from a clinical organization does not necessarily indicate that success has been attained.

 CN: Management of care; CL: Apply

134. 3. Overuse of nasal spray containing pseudoephedrine can lead to rhinitis medicamentosa, which is a rebound effect causing increased swelling and congestion. Use of pseudoephedrine nasal spray does not cause infections or thrush. Pseudoephedrine is not addictive.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


135. 2. The best way to teach a child about surgery is through play. The nurse can let the child handle the items that will be used for monitoring, such as the blood pressure cuff and the ECG pads. The child will become more familiar with the face masks he sees the surgical team wearing in the operating room after playing with one and wearing it before surgery. A child of this age-group does not understand detailed explanations of how to use equipment, such as a PCA, a VAS, or even a video. The pain scale that should be used for children is the FACES scale.

 CN: Basic care and comfort;
CL: Synthesize

136. 2. When a nurse observes the theft of an opioid, it is the responsibility of the nurse to report the incident to the supervisor of the unit. The supervisor of the unit can confront the coworker and notify the hospital's chief of security about the incident. In some situations, the drug-abusing coworker may be offered drug counseling. In situations in which the drugs are being sold, the police should be notified. The nurse should not confront the coworker because this may put the nurse in danger. It is not the responsibility of the nurse to notify federal drug agents about the incident.

 CN: Management of care; CL: Synthesize


137. 2. The nurse should teach the client and family the importance of not discontinuing benzotropine abruptly. Rather, the drug should be tapered slowly over a 1-week period. Benzotropine should not be used with over-the-counter cough and cold preparations because of the risk of an additive anticholinergic effect. Antacids delay the absorption of benzotropine, and alcohol in combination with benzotropine causes an increase in central nervous system depression; concomitant use should be avoided.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


138. 3. The nurse needs to focus on adverse effects that can be seen or felt, using a simple, brief, written description of the benefits of the medication and a list of common adverse effects and how to cope with them. The written format helps the client and family feel more in control by participating in treatment. They also can use the written information as a helpful resource for review. Information about all potential adverse effects, including percentages associated with each, will cause undue anxiety in the client and possibly overwhelm the client and family, negatively affecting compliance. The nurse should use discretion in selecting the content of educational sessions.

 CN: Health promotion and maintenance;
CL: Synthesize

139. 2. Albumin is a colloid that remains in the intravascular space, pulling fluid out of the intracellular and interstitial space. The client with nephrotic syndrome loses excessive amounts of protein, mainly albumin, in the urine. Because fluid is drawn into the intravascular space, blood pressure will increase. Crackles in the lung bases and cerebral edema are signs of circulatory overload or fluid volume excess. When edema is present in lower extremities, the skin feels cool to the touch unless an infection is present.

 CN: Physiological adaptation;
CL: Evaluate

140. 3. Although inherited, it is not clearly understood why cysts form in polycystic kidney disease. Environmental exposures promote development of bladder cancer. Although drinking alcohol requires the kidneys to excrete the alcohol, it is not thought to cause the kidneys to develop cysts.

 CN: Physiological adaptation;
CL: Synthesize

141. 1, 2, 3. A 3% sodium chloride solution is hypertonic; it will pull fluid into the intravascular compartment and may increase renal perfusion, so intake and output should be monitored. As fluid is pulled into the vasculature, the client may demonstrate signs of fluid overload such as jugular vein distention. Hyponatremia and hyperchloremia will produce neurologic signs and symptoms. Fluids should not be forced in a client with fluid overload. There is no need for an indwelling urinary catheter.


 CN: Reduction of risk potential;
CL: Apply

142. 3. The nurse expects the UAP assigned to several clients in labor to notify the nurse if the UAP observes that one of the clients has evidence of spontaneous rupture of the membranes. When the membranes rupture spontaneously, there is danger

of a prolapsed cord, a medical emergency requiring a cesarean delivery. Nausea may occur after administration of an epidural anesthetic, but this is not a priority or emergency. Having contractions that are 3 minutes apart and last for 40 seconds is normal during active labor. Because nalbuphine (Nubain) is an analgesic, it is normal for a client to fall asleep after I.V. administration of this drug.

 CN: Management of care; CL: Evaluate


143. 2. Before teaching a school-age child about a medical or nursing procedure, it is best to become familiar with the child's knowledge level. The nurse can then begin by explaining about the body structure involved in the procedure. Children of this age should be told about the unknown procedures far enough in advance for them to prepare for what is going to happen to them. Showing the child the equipment and explaining what is going to be done during the test should be done after the child is allowed to express what he knows about what is going to happen to him.

 CN: Psychosocial adaptation;
CL: Synthesize

144. 1, 2, 3, 4. Educating women about risk factors for cancers of the reproductive system is important. The nurse should encourage women to do breast and vulva self-exams. Limiting sexual activity during adolescence, using condoms, having fewer sexual partners, and not smoking reduces the risk of cervical cancer. Cancer can be prevented from occurring when screening reveals precancerous conditions of the vulva, cervix, or endometrium. Also, routine screening increases the chance that a cancer will be identified in its early stage. Immunization against HPV is recommended for preteen girls to prevent cervical cancer. Many cancers in women, particularly breast cancer, have a genetic basis and the woman's genetic history is an important tool in identifying risk.


 CN: Health promotion and maintenance;
CL: Create

145. 3. The client should be encouraged to keep up with his school work. The developmental task of the school-age child is industry versus inferiority. Keeping up with his peers is very important to this age-group. Watching television does provide rest, but it does not lead to a feeling of accomplishment. Coloring pictures is not an appropriate pastime for this age-group. Making crafts may be too strenuous of an activity for a client on bed rest.


 CN: Health promotion and maintenance;
CL: Synthesize

146. 4. Clients receiving TPN are at risk for a number of complications, including fluid imbalances such as fluid overload and hyperosmolar diuresis.


Other common complications include hyperglycemia, sepsis, pneumothorax, and air embolism. Hypostatic pneumonia, pulmonary hypertension, and orthostatic hypotension are not complications of TPN.

 CN: Pharmacological and parenteral therapies; CL: Analyze


147. 1, 2, 4. Heparin dosage in children is based on the child's weight. A bolus of heparin is administered by the I.V. route and the onset of action is immediate. The PTT is an indicator of the effectiveness of heparin. Following the heparin with a continuous infusion of heparin would cause life-threatening anticoagulation in this child. Penicillin and cephalosporins potentiate the effects of heparin, so the heparin must be carefully titrated to obtain maximum effect without causing an overdose. However, the antibiotic should not be discontinued.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


148. 1. Propantheline bromide (Pro-Banthine) is an anticholinergic drug. Common adverse effects include urine retention and constipation; flushed, dry skin; and dry mouth, nose, and throat. Orthostatic hypotension may also occur. Diarrhea and diaphoresis are adverse effects of cholinergic drugs.

 CN: Pharmacological and parenteral therapies; CL: Analyze

149. 1. Applying a tourniquet obstructs venous blood flow and, as a result, distends the veins. A tourniquet does not stabilize veins or immobilize the arm, nor is it applied to occlude arterial circulation.

 CN: Pharmacological and parenteral therapies; CL: Apply

150. 1. Prochlorperazine is administered postoperatively to control nausea and vomiting. Prochlorperazine is also used in psychotherapy because of its effects on mood and behavior. It is not used to treat dizziness, abdominal spasms, or abdominal distention.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

151. 1, 2, 3, 4. Cough and dyspnea can be present at the time of diagnosis of bone cancer, indicating that the cancer has metastasized to the lungs. About one-quarter of all adolescents with bone cancer have lung metastasis at the time of diagnosis. Pain and swelling result from the inflammation caused by the bone tumor and the increased vascularity of the tumor. At the time of diagnosis, fever, anorexia, and decreased range of motion have not occurred. The tumor involves the bone, so there is pain when pressure is exerted on the involved bone, but range of

motion is not affected. Fever and anorexia can occur if extensive metastasis has occurred.

 CN: Health promotion and maintenance; CL: Analyze


152. 1. The priority assessment is that the client has a firm fundus when gentle massage is used. This indicates that the client's fundus may be soft or "boggy" when it is not massaged. The receiving nurse should assess the client's fundus soon after admission and continue to monitor the client's fundus, lochia, and pulse rate. Postpartum hemorrhage is associated with uterine atony. Maternal-infant bonding is a process that usually starts on day 2 and ends at week 1. A 12-hour labor is normal. The temperature and pulse are within normal limits.

 CN: Management of care; CL: Analyze

153. 2. Assuming cultural appropriateness of eye contact with the client and his wife, this body language would make the nurse's nonverbal message congruent with the nurse's verbal message and demonstrate empathy. Directing their eyes only toward the client, rather than including the wife, ignores the wife. Avoiding eye contact with the client and wife or shifting the gaze between the client and wife conveys a lack of assurance about the nurse's focus and comments.

 CN: Psychosocial adaptation; CL: Apply

154. 4. Colleagues can be a source of suggestions and validation of communication strategies. The nurse has identified difficulty with the relationship and should seek assistance before discussing improved involvement with the client because improved involvement may not be the most appropriate approach. Positive and negative interactions occur in relationships. The frequency of both types of interactions determines the quality of an interpersonal relationship. In a therapeutic relationship, both parties contribute to the relationship; neither one should dominate or be submissive.


 CN: Psychosocial adaptation; CL: Synthesize

155. 3. The nurse on the postpartum unit should discuss with the client what her wishes are and mutually agree on a location. The charge nurse better understands the current and future needs of the client experiencing this type of loss as the client may or may not be thinking well or clearly at the moment. The postpartum unit is full of sounds of infants, and although being in a room by herself may support the need for separation, it is often in the best interest of the client to locate her away from the noise of the babies. Placing the client on another unit will remove her from the support she is seeking. On the other hand, she will not be hearing crying infants. This has often been the location


for someone experiencing a loss. Discharging the mother home as soon as she is stable physically is also a possibility, but the nurse must also assess the client's emotional stability and preferences for grieving.

 CN: Management of care; CL: Synthesize


156. 3. Confidentiality and privacy are critical developmental needs for the adolescent. These needs are important to enable the nurse to establish a relationship of trust with the adolescent. A sexual history should be conducted with a teen without parents. Therefore, the nurse should not ask the mother to provide information or put the daughter in a position of having to make a decision about her mother remaining in the room. Inform the adolescent that this information is confidential, and will not be shared with the parent. Inform the adolescent that issues of abuse or life-threatening issues are required by law to be disclosed to the authorities, and all other information is private.

 CN: Management of care; CL: Synthesize

157. 4. It is critical for medication safety to know the name, dosage, and times of administration of the medication taken at home. The family should bring the medication bottles to the hospital. The nurse should document the medication on the medical record from the bottles to ensure accuracy before the medication is ordered and administered. The pharmacist is a helpful resource, but the safest way to identify the medication is in its original container. It is not safe to assume the client could correctly identify the medications from a drug book. The medication regimen may have changed since the record 2 years ago.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

158. 3, 4, 5. The additional fluids should run through a separate line using a Y connector. The nurse must contact the surgeon to clarify if the client should receive the additional 100 mL/hour of I.V. fluids containing potassium chloride during the bolus infusion. Rapid infusion of potassium chloride can cause hyperkalemia with adverse cardiac outcomes such as arrhythmias. Bolus infusions of I.V. fluids should be run via an infusion pump to avoid excess fluid administration. Increasing the current I.V. infusion rate or adding additional fluids to the existing infusion is not safe because the current infusion contains potassium.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

159. 1. The nurse should notify the hospital's security staff about anyone who appears unusual. Typically the abductor is an older woman who wishes to have a baby. The nurse should take


only one baby at a time to a mother to prevent the neonate being taken to the wrong mother. Infants should never be left in the hallway. When in the mother's room, the infant should be placed away from the doorway to prevent or minimize the risk of abduction of the neonate. If an exit alarm is triggered, it is possible that an abductor is running away with an infant. Staff members should investigate the alarm immediately and stop the potential abductor. Hospital security can be alerted if someone is seen exiting the unit carrying a large bag or an infant.

 CN: Management of care; CL: Apply


160. 1. The client needs specific information about the effects of the drug, specifically its effect on the blood. The statement about weekly blood tests to determine safe dosage and monitoring for effects on the blood gives the client specific information to ensure follow-up with the required protocol for clozapine (Clozaril) therapy. Lack of accurate knowledge can lead to noncompliance with necessary follow-up procedures and noncompliance with medication. The supply of medication is not dependent on blood testing. Telling the client that his physician wants to know the progress does not provide specific information for this client. The blood tests are not required by the drug company.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


161. 4. A properly administered intradermal injection shows evidence of a bleb at the injection site. There should be no leaking of medication from the bleb; it needs to be absorbed into the tissue. Lack of swelling at the injection site means that the injection was given too deeply. The presence of tissue pallor does not indicate that the injection was given correctly.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


162. 1. A serious complication of I.V. therapy is fluid overload. Noisy respirations can develop as a result of pulmonary congestion. Additional symptoms of fluid overload include dyspnea, crackles, hypertension, bounding pulse, and distended neck veins.

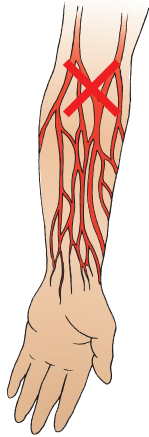
 CN: Pharmacological and parenteral therapies; CL: Analyze

163. 2. Only isotonic (normal) saline should be used when administering a blood transfusion. The use of dextrose or lactated Ringer's will cause the hemolysis of red blood cells.


 CN: Pharmacological and parenteral therapies; CL: Apply

164. 3. The median cubital vein is located in the approximate center of the antecubital space.


 CN: Pharmacological and parenteral therapies; CL: Apply



165. 2. Telling the mother that excess saliva is a common adverse effect of the drug is most helpful because it gives her information about the problem, thereby helping to decrease her anxiety about what is occurring with her son. By offering the paper cup, the nurse also demonstrates concern for the client, thereby leading to increased trust. Saying “I wonder if he’s having an adverse reaction to the medicine” shows the nurse’s lack of knowledge about the drug, decreases confidence in the nurse, and indicates poor judgment. Saying, “Don’t worry about it, it’s only a minor inconvenience compared to its benefits,” or telling the mother that the nurse has seen this happening to other clients is insensitive and does not assuage the mother’s anxiety.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

166. 1, 3, 4. The nurse should write down the order, read the order back to the physician, and receive confirmation from the physician that the order is correct as understood by the nurse. It is not necessary for the physician to come to the hospital to write the order on the chart or to have the nursing supervisor cosign the telephone order.


 CN: Safety and infection control; CL: Apply

167. 4. The nurse should take the client’s temperature and report the symptoms to the physician. Flulike symptoms of weakness, malaise, fever, sore throat, and lethargy may indicate leukopenia. An elevated temperature could also indicate an infection. Either condition requires medical intervention by the physician. Telling the client to wait another


day or to take over-the-counter flu medication is inappropriate because the client is at risk for leukopenia secondary to clozapine therapy and serious consequences could occur. Although it would be important to encourage the client to consume adequate fluids, the priority is to report the symptoms and check the temperature.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

168. 2. Protamine sulfate is a heparin antagonist. It is administered intravenously very slowly (over at least 10 minutes). Warfarin sodium and ASA have anticoagulant properties and would be contraindicated. Atropine sulfate is an anticholinergic drug and would not be effective in treating a heparin overdose.

 CN: Pharmacological and parenteral therapies; CL: Apply


169. 2. Aminophylline, a bronchodilator that relaxes smooth muscles in the bronchioles, is used in the treatment of emphysema to improve ventilation by dilating the bronchioles. Aminophylline does not have an effect on the diaphragm or the medullary respiratory center and does not promote pulmonary circulation.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


170. 1. Seven-year-olds like to play with friends of the same sex. In early school-age years, children enjoy the company of same-sex friends. Relatives become second-choice friends to those from school. Team games can be competitive, and the ego of a 7-year-old may be too fragile to endure losing the game without losing self-confidence. Infants enjoy solitary play. The school-age child enjoys cooperative play with friends of the same sex and age.

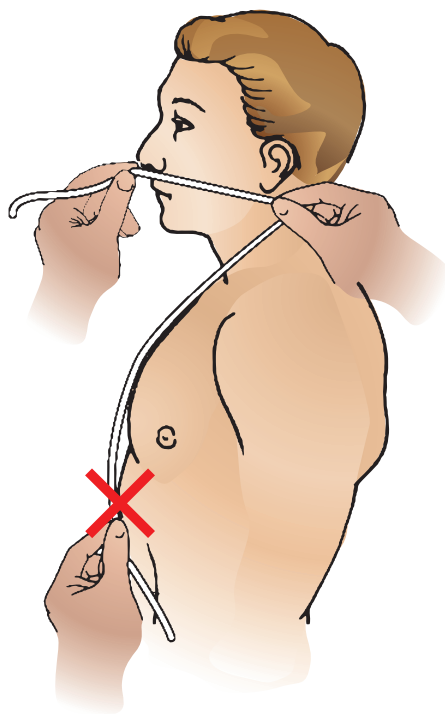
 CN: Health promotion and maintenance; CL: Analyze

171. 2. Trying something new is usually frightening for a 7-year-old. Separation anxiety is the most common fear between the ages of 5 months and 5 years of age. Injury and pain are a common fear of the preschool child. Fear of the opposite sex is common during adolescence.


 CN: Health promotion and maintenance; CL: Analyze

172. When measuring for NG tube insertion, the nurse would end the measurement at the xiphoid process.


 CN: Safety and infection control; CL: Apply



173. 4. The client is experiencing signs of thrombophlebitis. The nurse should notify the physician because emboli formation is a potential risk. Massaging the area may cause the thrombus to dislocate and become an embolus. Warm compresses will increase circulation to the area and may precipitate embolus formation. Ankle pump exercises are helpful in preventing thrombophlebitis but will not prevent further risk of embolus formation at this time.

 CN: Reduction of risk potential;
CL: Synthesize

174. 3. This rhythm is ventricular tachycardia, which is characterized by an absent P wave and a heart rate of 140 to 220 bpm. Ventricular tachycardia requires immediate intervention, usually with lidocaine (Xylocaine).

 CN: Physiological adaptation;
CL: Analyze

175.

3. Clear the area around the client.

1. Loosen clothing around the client's neck.

2. Turn the client on the side.

4. Suction the airway.

The goal of care for a client who is having a seizure is to prevent respiratory arrest and aspiration. The nurse should first clear the area around the client. Next, the nurse should loosen clothing around the client's neck


and turn the client on the side. As needed, the nurse can then suction the airway and administer oxygen.

 CN: Reduction of risk potential;
CL: Synthesize


176. 3. This rhythm is atrial fibrillation. It is characterized by an irregular QRS interval, no definite P waves before the QRS waves, and a ventricular rate greater than 100 bpm.

 CN: Reduction of risk potential; CL: Analyze


177. 1. During the first week postpartum, the client's pulse rate should be slow, with an average of 60 to 70 bpm. A pulse of 100 bpm warrants further investigation to rule out a possible infectious process or postpartum hemorrhage. An oral temperature of 99° F (36.8° C) is within normal limits. Excessive perspiration and frequent voiding in large amounts are caused by the normal diuresis that occurs as the body returns to its pre-pregnant state.

 CN: Management of care; CL: Synthesize


178. 1. Lymphedema occurs frequently after radical mastectomy when lymph nodes are removed. Aplasia, or the absence of lymph nodes, prevents proper lymph drainage. The tissue swelling is caused by obstructed lymph flow in the extremity. The blood pressure is taken in the unaffected arm to avoid further accumulation of lymphedema. An I.V. line should not be started in the affected arm. The nurse would encourage the client to elevate the extremity above the level of the heart. Blood draws in the affected arm should not be allowed.

 CN: Physiological adaptation;
CL: Synthesize

179. 4. The child's physician should be notified because the maximum daily recommended dosage for ceftriaxone (Rocephin) for this child's weight would be 3.3 g/day and giving this dose would administer 4 g/day. The nurse cannot administer a different dose than that ordered by the physician. There is no therapeutic serum level of Rocephin.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

180. 3. One of the staff members needs further instructions when the nurse observes the staff member wearing sterile gloves to bathe a newly delivered neonate at 1 hour of age. Clean gloves should be worn, not sterile gloves. Sterile gloves are more expensive than clean gloves and are not necessary when bathing a newly delivered neonate. Goggles should be worn when there is a possibility of blood and body fluid spatter. Bloody sheets should be placed in labeled containers for contaminated linens. Scalpel blades are disposed of in specified containers.

 CN: Safety and infection control;
CL: Evaluate

Appendices

- State and Territorial Boards of Nursing 1064
- Bibliography 1068

State and Territorial Boards of Nursing

Alabama Board of Nursing

770 Washington Avenue
RSA Plaza, Suite 250
Montgomery, AL 36130-3900
Phone: (334) 242-4060
Fax: (334) 242-4360
Website: <http://www.abn.state.al.us/>

Alaska Board of Nursing

Dept. of Comm. & Econ. Development
Div. of Occupational Licensing
3601 C Street, Suite 722
Anchorage, AK 99503
Phone: (907) 269-8161
Fax: (907) 269-8196
Website: <http://www.dced.state.ak.us/occ/pnur.htm>

Arizona State Board of Nursing

4747 N. 7th St.
Suite 200
Phoenix, AZ 85014
Phone: (602) 889-5150
Fax: (602) 889-5155
Website: <http://www.azbn.gov/>

Arkansas State Board of Nursing

University Tower Building
1123 S. University, Suite 800
Little Rock, AR 72204-1619
Phone: (501) 686-2700
Fax: (501) 686-2714
Website: <http://www.arsbn.arkansas.gov/Pages/default.aspx>

California State Board of Registered Nursing

400 R Street, Suite 4030
PO Box 944210
Sacramento, CA 95814
Phone: (916) 322-3350
Fax: (916) 327-4402
Website: <http://www.rn.ca.gov/>

Colorado Board of Nursing

1560 Broadway, Suite 880
Denver, Colorado 80202
Phone: (303) 894-2430
Fax: (303) 894-2821
Website: <http://www.dora.state.co.us/Nursing/>

Connecticut Board of Examiners for Nursing

Dept. of Public Health
410 Capitol Avenue, MS# 13PHO
PO Box 340308
Hartford, CT 06134-0328
Phone: (860) 509-7624
Fax: (860) 509-7553
Website: <http://www.ct.gov/dph/site/default.asp>

Delaware Board of Nursing

861 Silver Lake Blvd
Cannon Building, Suite 203
Dover, DE 19904
Phone: (302) 739-4522
Fax: (302) 739-2711
Website: <http://dpr.delaware.gov/boards/nursing/index.shtml>

District of Columbia Board of Nursing

Department of Health
825 N. Capitol Street, N.E., 2nd Floor
Room 2224
Washington, DC 20002
Phone: (202) 442-4778
Fax: (202) 442-9431
Website: <http://hpla.doh.dc.gov/hpla/cwp/view,a,1195,q,488526,hplanav,130661|.asp>

Florida Board of Nursing

4052 Bald Cypress Way, Bin #A07
Tallahassee, FL 32399-1708
Phone: (850) 245-4244
Website: <http://www.doh.state.fl.us/mqa/>

Georgia Board of Nursing

237 Coliseum Drive
Macon, GA 31217-3858
Phone: (478) 207-1640
Fax: (478) 207-1660
Website: <http://sos.georgia.gov/plb/rn/>

Hawaii Board of Nursing

Professional & Vocational Licensing Division
PO Box 3469
Honolulu, HI 96801
Phone: (808) 586-3000
Fax: (808) 586-2689
Website: <http://hawaii.gov/dcca/pvl/boards/nursing/>

Idaho Board of Nursing

280 N. 8th Street, Suite 210
 PO Box 83720
 Boise, ID 83720
 Phone: (208) 334-3110
 Fax: (208) 334-3262
 Website: <http://ibn.idaho.gov/>

Illinois Department of Professional Regulation

James R. Thompson Center
 100 West Randolph, Suite 9-300
 Chicago, IL 60601
 Phone: (312) 814-2715
 Fax: (312) 814-3145
 Website: <http://www.idfpr.com/>

Indiana State Board of Nursing

Health Professions Bureau
 402 W. Washington Street, Room W041
 Indianapolis, IN 46204
 Phone: (317) 232-2960
 Fax: (317) 233-4236
 Website: <http://www.in.gov/pla/>

Iowa Board of Nursing

River Point Business Park
 400 S.W. 8th Street
 Suite B
 Des Moines, IA 50309-4685
 Phone: (515) 281-3255
 Fax: (515) 281-4825
 Website: <http://www.state.ia.us/government/nursing/>

Kansas State Board of Nursing

Landon State Office Bldg.
 900 SW Jackson, Suite 551 S.
 Topeka, KS 66612-1230
 Phone: (785) 296-4929
 Fax: (785) 296-3929
 Website: <http://www.ksbn.org/>

Kentucky Board of Nursing

312 Whittington Parkway, Suite 300
 Louisville, KY 40222
 Phone: (502) 329-7000
 Fax: (502) 329-7011
 Website: <http://kbn.ky.gov/>

Louisiana State Board of Nursing

3510 N. Causeway Boulevard, Suite 501
 Metairie, LA 70003
 Phone: (504) 838-5332
 Fax: (504) 838-5349
 Website: <http://www.lsbns.state.la.us/>

Maine State Board of Nursing

158 State House Station
 Augusta, ME 04333
 Phone: (207) 287-1133
 Fax: (207) 287-1149
 Website: <http://www.maine.gov/boardofnursing/>

Maryland Board of Nursing

4140 Patterson Avenue
 Baltimore, MD 21215
 Phone: (410) 585-1900
 Fax: (410) 358-3530
 Website: <http://www.mbon.org/main.php>

Massachusetts Nursing State Board

Commonwealth of Massachusetts
 239 Causeway Street
 Boston, MA 02114
 Phone: (617) 973-0800
 Fax: (617) 727-1630
 Website: <http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Provider&L2=Certification%2c+Licensure%2c+and+Registration&L3=Occupational+and+Professional&L4=Nursing&sid=Eeohhs2>

Michigan CIS/Office of Health Services

Ottawa Towers North
 611 W. Ottawa, 4th Floor
 Lansing, MI 48933
 Phone: (517) 373-9102
 Fax: (517) 373-2179
 Website: <http://www.michigan.gov/dleg>

Minnesota Board of Nursing

2829 University Avenue SE
 Suite 500
 Minneapolis, MN 55414
 Phone: (612) 617-2270
 Fax: (612) 617-2190
 Website: <http://www.state.mn.us/portal/mn/jsp/home.do?agency=NursingBoard>

Mississippi Board of Nursing

1935 Lakeland Drive, Suite B
 Jackson, MS 39216-5014
 Phone: (601) 987-4188
 Fax: (601) 364-2352
 Website: <http://www.msbn.state.ms.us/>

Missouri State Board of Nursing

3605 Missouri Blvd
 P.O. Box 656
 Jefferson City, MO 65102-0656
 Phone: (573) 751-0681
 Fax: (573) 751-0075
 Website: <http://www.pr.mo.gov/>

Montana State Board of Nursing

PO Box 200513
 Helena, MT 59620-0513
 Phone: (406) 841-2345
 Fax: (406) 841-2305
 Website: http://bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp

Nebraska Health and Human Services System

Dept. of Regulation & Licensure, Nursing Section
301 Centennial Mall South
Lincoln, NE 68509-4986
Phone: (402) 471-4376
Fax: (402) 471-3577
Website: <http://www.hhs.state.ne.us/crl/nursing/nursingindex.htm>

Nevada State Board of Nursing

License Certification and Education
4330 S. Valley View Blvd
Suite 106
Las Vegas, NV 89103
Phone: (702) 486-5800
Fax: (702) 486-5803
Website: <http://www.nursingboard.state.nv.us/>

New Hampshire Board of Nursing

P.O. Box 3898
78 Regional Drive, BLDG B
Concord, NH 03302
Phone: (603) 271-2323
Fax: (603) 271-6605
Website: <http://www.nh.gov/nursing/>

New Jersey Board of Nursing

P.O. Box 45010
124 Halsey Street, 6th Floor
Newark, NJ 07101
Phone: (973) 504-6586
Fax: (973) 648-3481
Website: <http://www.state.nj.us/lps/ca/medical.htm>

New Mexico Board of Nursing

4206 Louisiana Boulevard, NE
Suite A
Albuquerque, NM 87109
Phone: (505) 841-8340
Fax: (505) 841-8347
Website: <http://www.bon.state.nm.us/>

New York State Board of Nursing

Education Bldg.
89 Washington Avenue
2nd Floor West Wing
Albany, NY 12234
Phone: (518) 474-3817 Ext. 120
Fax: (518) 474-3706
Website: <http://www.op.nysed.gov/prof/nurse/>

North Carolina Board of Nursing

3724 National Drive, Suite 201
Raleigh, NC 27612
Phone: (919) 782-3211
Fax: (919) 781-9461
Website: <http://www.ncbon.com/>

North Dakota Board of Nursing

919 South 7th Street, Suite 504
Bismark, ND 58504
Phone: (701) 328-9777
Fax: (701) 328-9785
Website: <http://www.ndbon.org/>

Ohio Board of Nursing

17 South High Street, Suite 400
Columbus, OH 43215-3413
Phone: (614) 466-3947
Fax: (614) 466-0388
Website: <http://www.nursing.ohio.gov/>

Oklahoma Board of Nursing

2915 N. Classen Boulevard, Suite 524
Oklahoma City, OK 73106
Phone: (405) 962-1800
Fax: (405) 962-1821
Website: <http://www.ok.gov/nursing/>

Oregon State Board of Nursing

800 NE Oregon Street, Box 25
Suite 465
Portland, OR 97232
Phone: (503) 731-4745
Fax: (503) 731-4755
Website: <http://www.osbn.state.or.us/>

Pennsylvania State Board of Nursing

124 Pine Street
Harrisburg, PA 17101
Phone: (717) 783-7142
Fax: (717) 783-0822
Website: http://www.dos.state.pa.us/portal/server.pt/community/bureau_of_professional_occupational_affairs/12483

Rhode Island Board of Nursing

Registration and Nursing Education
105 Cannon Building
Three Capitol Hill
Providence, RI 02908
Phone: (401) 222-5700
Fax: (401) 222-3352
Website: <http://www.healthri.org/>

South Carolina State Board of Nursing

110 Centerview Drive
Suite 202
Columbia, SC 29210
Phone: (803) 896-4550
Fax: (803) 896-4525
Website: <http://www.llr.state.sc.us/pol/nursing/>

South Dakota Board of Nursing

4300 South Louise Ave., Suite C-1
Sioux Falls, SD 57106-3124
Phone: (605) 362-2760
Fax: (605) 362-2768
Website: <http://doh.sd.gov/boards/nursing/>

Tennessee State Board of Nursing

426 Fifth Avenue North
1st Floor - Cordell Hull Building
Nashville, TN 37247
Phone: (615) 532-5166
Fax: (615) 741-7899
Website: <http://health.state.tn.us/boards/nursing/>

Texas Board of Nurse Examiners

333 Guadalupe, Suite 3-460
Austin, TX 78701
Phone: (512) 305-7400
Fax: (512) 305-7401
Website: <http://www.bne.state.tx.us/>

Utah State Board of Nursing

Heber M. Wells Bldg., 4th Floor
160 East 300 South
Salt Lake City, UT 84111
Phone: (801) 530-6628
Fax: (801) 530-6511
Website: <http://www.dopl.utah.gov/licensing/nursing.html>

Vermont State Board of Nursing

109 State Street
Montpelier, VT 05609-1106
Phone: (802) 828-2396
Fax: (802) 828-2484
Website: <http://www.vtprofessionals.org/opr1/nurses/>

Virginia Board of Nursing

6606 W. Broad Street, 4th Floor
Richmond, VA 23230
Phone: (804) 662-9909
Fax: (804) 662-9512
Website: <http://www.dhp.state.va.us/>

Washington State Nursing Care Quality Assurance Commission

Department of Health
1300 Quince Street SE
Olympia, WA 98504-7864
Phone: (360) 236-4740
Fax: (360) 236-4738
Website: <http://www.doh.wa.gov/hsqa/professions/nursing/default.htm>

West Virginia Board of Examiners for Registered Professional Nurses

101 Dee Drive
Charleston, WV 25311
Phone: (304) 558-3596
Fax: (304) 558-3666
Website: <http://www.wvrnboard.com/>

Wisconsin Department of Regulation and Licensing

1400 E. Washington Avenue
P.O. Box 8935
Madison, WI 53708
Phone: (608) 266-0145
Fax: (608) 261-7083
Website: <http://www.drl.state.wi.us/>

Wyoming State Board of Nursing

2020 Carey Avenue, Suite 110
Cheyenne, WY 82002
Phone: (307) 777-7601
Fax: (307) 777-3519
Website: <https://nursing-online.state.wy.us/>

Bibliography

1. The Nursing Care of the Childbearing Family

- Pillitteri, A. (2009). *Maternal & child health nursing: Care of the childbearing and childrearing family* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Ricci, S. & Kyle, T. (2008). *Maternity and Pediatric Nursing*. Philadelphia: Lippincott, Williams & Wilkins.
- Simpson, K.R., & Creehan, P.A. (2007). *Association of women's health, obstetric, and neonatal nurses (AWHONN) perinatal nursing* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Witt, C. (2007). *Advances in neonatal care*. Philadelphia: Lippincott Williams & Wilkins.

2. The Nursing Care of Children

- Kyle, T. (2007). *Essentials of Pediatric Nursing*. Philadelphia: Lippincott, Williams & Wilkins.
- Pillitteri, A. (2009). *Maternal & child health nursing: Care of the childbearing and childrearing family* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Ricci, S. & Kyle, T. (2008). *Maternity and Pediatric Nursing*. Philadelphia: Lippincott, Williams & Wilkins.

3. The Nursing Care of Adults with Medical and Surgical Health Problems

- Ellis, J., & Hartley, C. (2008). *Managing and coordinating nursing care*. (5th ed.) Philadelphia: Lippincott Williams & Wilkins.

- Karch, A. (2010). *Lippincott's nursing drug guide*. Philadelphia: Lippincott Williams & Wilkins.
- Marquis, B. & Huston, C. (2008). *Leadership roles and management functions in nursing*. Philadelphia: Lippincott, Williams & Wilkins.
- Smeltzer, B., et al. (2009). *Brunner and Suddarth's textbook of medical-surgical nursing* (12th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Taylor, C. et al. (2006). *Fundamentals of nursing*. Philadelphia: Lippincott Williams & Wilkins.
- Weber, J.R., & Kelley, J. (2007). *Nurses handbook of health assessment*. Philadelphia: Lippincott Williams & Wilkins

4. The Nursing Care of Clients with Psychiatric Disorders and Mental Health Problems

- Andrews, M., & Boyle, J. (2007). *Transcultural concepts in nursing care* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Boyd, M.A. (2007). *Psychiatric nursing contemporary practice* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Karch, A. (2010). *Lippincott's nursing drug guide*. Philadelphia: Lippincott Williams & Wilkins.
- Shives, L.R. (2007) *Basic concepts of psychiatric mental health nursing*. Philadelphia: Lippincott Williams & Wilkins.
- Videbeck, S. (2007). *Psychiatric mental health nursing*. Philadelphia: Lippincott Williams & Wilkins.

About the CD-ROM

This *Lippincott's Q&A Review for NCLEX-RN*[®] CD-ROM is just another reason why the book in your hands is so highly regarded by students and faculty. With more than 1,300 NCLEX-style questions (all formats including new audio, video, and graphic formats), this easy-to-use program provides even more practice that is sure to lead you to exam excellence!

Minimum system requirements

- Windows XP
- Pentium 4
- 512 MB RAM
- 20 MB of free hard-disk space
- SVGA monitor with high color (16-bit)
- CD-ROM drive
- mouse.

Installation

Place the *Lippincott's Q&A Review for NCLEX-RN*[®] CD-ROM into your CD-ROM drive. After a few moments, the install process will automatically begin. *Note:* If the install process

doesn't automatically begin, click the Start button on your computer and select "Run." At the command line, type *D:\setup.exe*, where the letter D represents your CD-ROM drive. If your drive is designated by a different letter, use the letter of your drive instead. Then click OK. Follow the installation instructions.

Technical support

For technical support, call toll-free 1-800-468-1128, Monday through Friday, 8:30 a.m. to 7 p.m. Eastern Time. You may also write to Lippincott Williams & Wilkins Technical Support, 351 W. Camden Street, Baltimore, MD 21201-2436, or e-mail support at techsupp@lww.com.

