NCLEX

Exam Questions NCLEX-PN

National Council Licensure Examination(NCLEX-PN)

NEW QUESTION 1
- (Topic 1)
While undergoing fetal heart monitoring, a pregnant Native-American woman requests that a medicine woman be present in the examination room. Which of the following is an appropriate response by the nurse?

A. ??I will assist you in arranging to have a medicine woman present.??
B. ??We do not allow medicine women in exam rooms.??
C. ??That does not make any difference in the outcome.??
D. ??It is old-fashioned to believe in that.??

Answer: A

Explanation:
This statement reflects cultural awareness and acceptance that receiving support from a medicine woman is important to the client. The other statements are culturally insensitive and unprofessional.
Reduction of Risk Potential

NEW QUESTION 2
- (Topic 1)
Erythropoietin used to treat anemia in clients with renal failure should be given in conjunction with:

A. iron, folic acid, and B12.
B. an increase of protein in the diet.
C. vitamins A and C.
D. an increase of calcium in the diet.

Answer: A

Explanation:
The kidneys of a client in renal failure produce no erythropoietin, a hormone necessary for RBC production.
Erythropoietin can be given as replacement, but the client needs adequate iron, folate, and B12 to increase the effectiveness of EPO. Choice 2 is not necessary for RBC production and can increase uremia. Choices 3 and 4 are not necessary for RBC production.Physiological Adaptation

NEW QUESTION 3
- (Topic 1)
Which of the following organs of the digestive system has a primary function of absorption?

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

Answer: C

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

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

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

Answer: C

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

NEW QUESTION 5
- (Topic 1)
Which of the following might be an appropriate nursing diagnosis for an epileptic client?

A. Dysreflexia
B. Risk for Injury
C. Urinary Retention
D. Unbalanced Nutrition

Answer:

B

Explanation:
The epileptic client is at risk for injury due to the complications of seizure activity, such as possible head trauma associated with a fall. The other choices are not related to the question.Reduction of Risk Potential

NEW QUESTION 6
- (Topic 1)
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

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

Answer: C

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

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

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

Answer: B

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

NEW QUESTION 8
- (Topic 1)
All of the following factors, when identified in the history of a family, are correlated with poverty except:

A. high infant mortality rate.
B. frequent use of Emergency Departments.
C. consultation with folk healers.
D. low incidence of dental problems.

Answer: D

Explanation:
Dental problems are prevalent because of the lack of preventive care and access to care.
High infant mortality is one of the most significant problems correlated with poverty. Pregnant women who do not have access to care might come to the Emergency Department when in labor. Those in poverty are likely to use Emergency Departments because they may not be turned away. Those in poverty might also turn to folk healers or other persons in their community for care who might be easier to access and might not demand payment.Health Promotion and Maintenance

NEW QUESTION 9
- (Topic 1)
What interpersonal relief behavior is Ashley using?

A. acting out
B. somatizing
C. withdrawal
D. problem-solving

Answer: B

Explanation:
Somatizing means one experiences an emotional conflict as a physical symptom. Ashley manifests several physical symptoms associated with severe anxiety. Acting out refers to behaviors such as anger, crying, laughter, and physical or verbal abuse. Withdrawal is a reaction in which psychic energy is withdrawn from the environment and focused on the self in response to anxiety. Problem-solving takes place when anxiety is identified and the unmet need is met.Psychosocial Integrity

NEW QUESTION 10
- (Topic 1)
A diet high in fiber content can help an individual to:

A. lose body weight fast.
B. reduce diabetic ketoacidosis.
C. lower cholesterol.
D. reduce the need for folate.

Answer: C

Explanation:
Fiber-rich foods (such as grains, apples, potatoes, and beans) can help lower cholesterol.
Nonpharmacological Therapies

NEW QUESTION 10
- (Topic 1)
Which sign might the nurse see in a client with a high ammonia level?

A. coma
B. edema
C. hypoxia
D. polyuria

Answer: A

Explanation:
Coma might be seen in a client with a high ammonia level.Reduction of Risk Potential

NEW QUESTION 11
- (Topic 1)
For a client with suspected appendicitis, the nurse should expect to find abdominal tenderness in which quadrant?

A. upper right
B. upper left
C. lower right
D. lower left

Answer: C

Explanation:
The nurse should expect to find abdominal tenderness in the lower-right quadrant in a client with appendicitis.
Physiological Adaptation

NEW QUESTION 16
- (Topic 1)
The kind of man who beats a woman is:

A. from a minority culture in a low-income group.
B. from a majority culture in a middle-income group.
C. one who was never allowed to compete as a child.
D. from any walk of life, race, income group, or profession.

Answer: D

Explanation:
Batterers cannot be predicted by demographic features related to age, ethnicity, race, religious denomination, education, socioeconomic status, or class. Ninety-five percent of domestic abuse cases
involve male perpetrators and female victims.Psychosocial Integrity

NEW QUESTION 17
- (Topic 1)
The nurse is teaching parents of a newborn about feeding their infant. Which of the following instructions should the nurse include?

A. Use the defrost setting on microwave ovensto warm bottles.
B. When refrigerating formula, don??t feed the baby partially used bottles after 24 hours.
C. When using formula concentrate, mix two parts water and one part concentrate.
D. If a portion of one bottle is left for the next feeding, go ahead and add new formula to fill it.

Answer: A

Explanation:
Parents must be careful when warming bottles in a microwave oven because the milk can become superheated.
When a microwave oven is used, the defrost setting should be chosen, and the temperature of the formula should be checked before giving it to the baby. Refrigerated, partially used bottles should be discarded after 4 hours because the baby might have introduced some pathogens into the formula. Returning the bottle to the refrigerator does not destroy pathogens. Formula concentrate and water are usually mixed in a 1:1 ratio of one part concentrate and one part water. Infants should be offered fresh formula at each feeding. Partially used bottles should not have fresh formula added to them. Pathogens can grow in partially used bottles of formula and be transferred to the new formula.Health Promotion and Maintenance

NEW QUESTION 22
- (Topic 1)
Which of the following instructions should the nurse give a client who will be undergoing mammography?

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

Answer: B

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

NEW QUESTION 27
- (Topic 1)
Teaching about the need to avoid foods high in potassium is most important for which client?

A. a client receiving diuretic therapy
B. a client with an ileostomy
C. a client with metabolic alkalosis
D. a client with renal disease

Answer: D

Explanation:
Clients with renal disease are predisposed to hyperkalemia and should avoid foods high in potassium.
Choices 1, 2, and 3 are incorrect because clients receiving diuretics with ileostomy or with metabolic alkalosis are at risk for hypokalemia and should be encouraged to eat foods high in potassium.
Physiological Adaptation

NEW QUESTION 28
- (Topic 1)
Which of the following is an inappropriate item to include in planning care for a severely neutropenic client?

A. Transfuse netrophils (granulocytes) to prevent infection.
B. Exclude raw vegetables from the diet.
C. Avoid administering rectal suppositories.
D. Prohibit vases of fresh flowers and plants in the client??s room.

Answer: A

Explanation:
Granulocyte transfusion is not indicated to prevent infection. Produced in the bone marrow, granulocytes
normally comprise 70% of all WBCs. They are subdivided into three types based on staining properties:
neutrophils, eosinophils, and basophils. They can be beneficial in a selected population of infected, severely granulocytopenic clients (less than 500/mm3) who do not respond to antibiotic therapy and who are expected to experience prolonged suppression of granulocyte production.Physiological Adaptation

NEW QUESTION 31
- (Topic 1)
Which of the following injuries, if demonstrated by a client entering the Emergency Department, is the highest priority?

A. open leg fracture
B. open head injury
C. stab wound to the chest
D. traumatic amputation of a thumb

Answer: C

Explanation:
A stab wound to the chest might result in lung collapse and mediastinal shift that, if untreated, could lead to
death. Treatment of an obstructed airway or a chest wound is a higher priority than hemorrhage. The principle of ABC (airway, breathing, and circulation) prioritizes care decisions.Physiological Adaptation

NEW QUESTION 36
- (Topic 1)
Which is the proper hand position for performing chest percussion?

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

Answer: A

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

NEW QUESTION 37
- (Topic 1)
A client comes to the clinic for assessment of his physical status and guidelines for starting a weight-reduction diet. The client??s weight is 216 pounds and his height is 66 inches. The nurse identifies the BMI (body mass index) as:

A. within normal limits, so a weight-reduction diet is unnecessary.
B. lower than normal, so education about nutrient-dense foods is needed.
C. indicating obesity because the BMI is 35.
D. indicating overweight status because the BMI is 27.

Answer: C

Explanation:
Obesity is defined by a BMI of 30 or more with no co-morbid conditions. It is calculated by utilizing a chart
or nomogram that plots height and weight. This client??s BMI is 35, indicating obesity. Goals of diet therapy are aimed at decreasing weight and increasing activity to healthy levels based on a client??s BMI, activity status, and energy requirements.Physiological Adaptation

NEW QUESTION 39
- (Topic 1)
Diagnostic genetic counseling, for procedures such as amniocentesis and chorionic villus sampling, allows clients to make all of the following choices except:

A. terminating the pregnancy.
B. preparing for the birth of a child with special needs.
C. accessing support services before the birth.
D. completing the grieving process before the birth.

Answer: D

Explanation:
If findings are ominous, the grieving process will not be completed before birth. If the couple elects to
terminate a pregnancy based on diagnostic tests, there will be grief and concerns for future pregnancies. Couples might choose to access support services and prepare for the birth of an infant with special needs. Some fetal conditions can be treated in utero.Health Promotion and Maintenance

NEW QUESTION 42
- (Topic 1)
Which of the following medications is a serotonin antagonist that might be used to relieve nausea and vomiting?

A. metoclopramide (Reglan)
B. onedansetron (Zofran)
C. hydroxyzine (Vistaril)
D. prochlorperazine (Compazine)

Answer: B

Explanation:
Zofran is a serotonin antagonist that can be used to relieve nausea and vomiting. The other medications can be used for nausea and vomiting, but they have different mechanisms of action.
Physiological Adaptation

NEW QUESTION 44
- (Topic 1)
When the nurse is determining the appropriate size of an oropharyngeal airway to insert, what part of a client??s body should she measure?

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

Answer: A

Explanation:
An oropharyngeal airway is measured from the corner of the client??s mouth, to the tragus of the ear.
Reduction of Risk Potential

NEW QUESTION 46
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

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

Answer: D

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

NEW QUESTION 49
- (Topic 1)
A client turns her ankle. She is diagnosed as having a Pulled Ligament. This should be documented as a:

A. sprain.
B. strain.
C. subluxation.
D. distoration.

Answer: B

Explanation:
A strain is excessive stretching of a ligament. A sprain involves a twisting motion involving muscles.Basic Care and Comfort

NEW QUESTION 50
- (Topic 1)
Which of the following nursing actions is most effective when evaluating a kinetic family drawing?

A. telling the child to draw their family doing something
B. offering specific suggestions of what to include in the drawing
C. discouraging the child from talking about the drawing
D. noting the omission of any family members

Answer: D

Explanation:
There are several guidelines for evaluating kinetic family drawings, including Choice 4.
Effective nursing actions include asking the child to explain what each family member is doing, encouraging him or her to tell as much as possible about the drawing, noting physical intimacy or distance, noting placement of family members in the drawing, noting facial expressions of family members and noting if they are facing each other or turned away.
Choice 1 is initial instruction, not evaluation. Only general encouragement should be given to avoid suggesting themes to the child.Health Promotion and Maintenance

NEW QUESTION 51
- (Topic 1)
Which of the following terms refers to soft-tissue injury caused by blunt force?

A. contusion
B. strain
C. sprain
D. dislocation

Answer: A

Explanation:
A contusion is a soft-tissue injury caused by blunt force. It is an injury that does not break the skin, is caused by a blow and is characterized by swelling, discoloration, and pain. The immediate application of cold might limit the development of a contusion. A strain is a muscle pull from overuse, overstretching, or excessive stress.
A sprain is caused by a wrenching or twisting motion. A dislocation is a condition in which the articular surfaces of the bones forming a joint are no longer in anatomic contact.Physiological Adaptation

NEW QUESTION 54
- (Topic 1)
Which of the following values should the nurse monitor closely while a client is on total parenteral nutrition?

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

Answer: C

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

NEW QUESTION 55
- (Topic 1)
An appropriate intervention for the client with suspected genitourinary trauma and visible blood at the urethral meatus is:

A. insertion of a Foley catheter.
B. in and out catheter specimen for urinalysis.
C. a voided urine specimen for urinalysis.
D. a urologist consult.

Answer: D

Explanation:
A urologist consult is appropriate for a client with visible blood at the urethral meatus and suspected trauma.
Choices 1 and 2 are contraindicated. A urinalysis might be ordered by the physician, but the question does not provide enough information to make Choice 3 the correct answer.Physiological Adaptation

NEW QUESTION 58
- (Topic 1)
Which of the following indicates a hazard for a client on oxygen therapy?

A. A No Smoking sign is on the door.
B. The client is wearing a synthetic gown.
C. Electrical equipment is grounded.
D. Matches are removed.

Answer: B

Explanation:
A synthetic gown might generate sparks of static electricity, which can be a fire hazard, particularly in the presence of oxygen. The client on oxygen therapy should wear a cotton gown. The remaining options are appropriate safety measures.Reduction of Risk Potential

NEW QUESTION 63
- (Topic 1)
Acyclovir is the drug of choice for:

A. HIV.
B. HSV 1 and 2 and VZV.
C. CMV.
D. influenza A viruses.

Answer: B

Explanation:
Acyclovir (Zovirax) is specific for treatment of herpes virus infections. There is no cure for herpes. Acyclovir is excreted unchanged in the urine and therefore must be used cautiously in the presence of renal impairment. Drugs that treat herpes inhibit viral DNA replication by competing with viral substrates to form shorter, ineffective DNA chains.Physiological Adaptation

NEW QUESTION 64
- (Topic 1)
The nurse is assessing the dental status of an 18-month-old child. How many teeth should the nurse expect to examine?

A. 6
B. 8
C. 12
D. 16

Answer: C

Explanation:
In general, children begin dentition around 6 months of age. During the first 2 years of life, a quick guide to the number of teeth a child should have is as follows: Subtract the number 6 from the number of months in the age of the child. In this example, the child is 18 months old, so the formula is 18 – 6 = 12.
An 18-month-old child should have approximately 12 teeth.Health Promotion and Maintenance

NEW QUESTION 66
- (Topic 1)
Which fetal heart monitor pattern can indicate cord compression?

A. variable decelerations
B. early decelerations
C. bradycardia
D. tachycardia

Answer: A

Explanation:
Variable decelerations can be related to cord compression. The other patterns are not.
Reduction of Risk Potential

NEW QUESTION 68
- (Topic 1)
A client with which of the following conditions is at risk for developing a high ammonia level?

A. renal failure
B. psoriasis
C. lupus
D. cirrhosis

Answer: D

Explanation:
A client with cirrhosis is at risk for developing a high ammonia level.Reduction of Risk Potential

NEW QUESTION 70
- (Topic 1)
How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?

A. every 24 hours
B. every 36 hours
C. every 48 hours
D. every 72 hours

Answer: A

Explanation:
The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to the high risk of bacterial growth.Health Promotion and Maintenance

NEW QUESTION 72
- (Topic 1)
When obtaining a health history on a menopausal woman, which information should a nurse recognize as a contraindication for hormone replacement therapy?

A. family history of stroke
B. ovaries removed before age 45
C. frequent hot flashes and/or night sweats
D. unexplained vaginal bleeding

Answer: D

Explanation:
Unexplained vaginal bleeding is a contraindication for hormone replacement therapy. Family history of
stroke is not a contraindication for hormone replacement therapy. If the woman herself had a history of stroke or other blood-clotting events, hormone therapy could be contraindicated. Frequent hot flashes and/or night sweats can be relieved by hormone replacement therapy.Health Promotion and Maintenance

NEW QUESTION 77
- (Topic 1)
All of the following should be performed when fetal heart monitoring indicates fetal distress
except:

A. increase maternal fluids.
B. administer oxygen.
C. decrease maternal fluids.
D. turn the mother.

Answer: C

Explanation:
Decreasing maternal fluids is the only intervention that shouldnotbe performed when fetal distress is indicated.Reduction of Risk Potential

NEW QUESTION 82
- (Topic 2)
The vast majority of deaths resulting from unintentional poisoning occur in:

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

Answer: B

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

NEW QUESTION 87

- (Topic 2)
The nurse teaching an obese client about nutritional needs and weight loss should include all of the following except:

A. knowledge of food and food products.
B. development of a positive mental attitude.
C. adequate exercise.
D. starting a fast weight-loss diet.

Answer: D

Explanation:
Start a fast weight-loss diet.Health Promotion and Maintenance

NEW QUESTION 92
- (Topic 2)
In performing a psychosocial assessment, the nurse begins by asking questions that encourage the client to describe problematic behaviors and situations. The next step is to elicit the client??s:

A. feelings about what has been described.
B. thoughts about what has been described.
C. possible solutions to the problem.
D. intent in sharing the description.

Answer: B

Explanation:
Questions should be asked in a precise order (specifically, from the most-simple description to the moredifficult disclosure of feelings). When the problems have been described, eliciting the client??s thoughts about the dilemmas provides further assessment data as well as the client??s interpretation of what has happened. Feelings, solutions and articulating intent are more complex processes.Psychosocial Integrity

NEW QUESTION 95
- (Topic 2)
A nurse is planning a brief treatment program for a client who was raped. A realistic, short- term goal is to:

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

Answer: D

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

NEW QUESTION 100
- (Topic 2)
A nurse observes a client sitting alone and talking. When asked, the client reports that he is ??talking to the voices.?? The nurse??s next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Answer: A

Explanation:
Nurses need to inform clients that there is a difference in perceptions and pay attention to the content of hallucinations. The other options are not therapeutic.Psychosocial Integrity

NEW QUESTION 103
- (Topic 2)
High uric acid levels can develop in clients who are receiving chemotherapy. This can be caused by:

A. the inability of the kidneys to excrete the drug metabolites.
B. rapid cell catabolism.
C. toxic effects of the prophylactic antibiotics that are given concurrently.
D. the altered blood pH from the acid medium of the drugs.

Answer: B

Explanation:
Chemotherapy causes damage to cells, and uric acid is a cell metabolite.Physiological Adaptation

NEW QUESTION 107
- (Topic 2)

A client recently lost a child due to poisoning. The client tells the nurse, ??I don??t want to make any new friends right now.?? This is an example of which of the following indicators of stress?

A. emotional behavioral indicator
B. spiritual indicator
C. sociocultural indicator
D. intellectual indicator

Answer: C

Explanation:
Stress can alter a person??s relationships with others.Psychosocial Integrity

NEW QUESTION 108
- (Topic 2)
The nurse is caring for a client who is dying. While assessing the client for signs of impending death, the nurse observes the client for:

A. elevated blood pressure.
B. Cheyne-Stokes respiration.
C. elevated pulse rate.
D. decreased temperature.

Answer: B

Explanation:
Cheyne-Stokes respirations are rhythmic waxing and waning of respirations from very deep breathing to very shallow breathing with periods of temporary apnea, often associated with cardiac failure.
This can be a sign of impending death.Psychosocial Integrity

NEW QUESTION 110
- (Topic 2)
The death of a beloved spouse places the surviving partner in which type of crisis?

A. maturational
B. reactive
C. nonreactive
D. situational

Answer: D

Explanation:
A situational crisis is an unexpected, unplanned event, such as the death of a spouse.
Option 1 is a normal maturational crisis; Choices 2 and 3 are not recognized crisis states.Coordinated Care

NEW QUESTION 111
- (Topic 2)
A client goes to the Emergency Department with acute respiratory distress and the following arterial blood gases (ABGs): pH 7.35, PCO2 40 mmHg, PO2 63mmHg, HCO3 23, and oxygenation saturation (SaO2) 93%. Which of the following represents the best analysis of the etiology of these ABGs?

A. tuberculosis (TB)
B. pneumonia
C. pleural effusion
D. hypoxia

Answer: D

Explanation:
A combined low PO2 and lowSaO2 indicates hypoxia. The pH, PCO2, and HCO3 are normal. ABGs are not
necessarily altered in TB or pleural effusion. Depending on the degree of the pneumonia, the PO2 and PCO2 might be low because hypoxia stimulates hyperventilation.Physiological Adaptation

NEW QUESTION 113
- (Topic 2)
The chemotherapeutic DNA alkylating agents such as nitrogen mustards are effective because they:

A. cross-link DNA strands with covalent bonds between alkyl groups on the drug and guanine bases on DNA.
B. have few, if any, side effects.
C. are used to treat multiple types of cancer.
D. are cell-cycle-specific agents.

Answer: A

Explanation:
Alkylating agents are highly reactive chemicals that introduce alkyl radicals into biologically active molecules and thereby prevent their proper functioning, replication, and transcription. Choice 2 is incorrect because alkylating agents have numerous side effects including alopecia, nausea, vomiting, and myelosuppression. Choice 3 is incorrect because nitrogen mustards have a broad spectrum of activity against chronic lymphocytic leukemia, non-Hodgkin??s lymphoma, and breast and ovarian cancer, but they are effective chemotherapeutic agents because of DNA crosslinkage. Choice 4 is incorrect because alkylating agents are non-cell-cycle- specific agents.PharmacologicalTherapies

NEW QUESTION 114
- (Topic 2)
The client??s lab culture report is negative for a suspected infection. A test that can correctly identify those who do not have a given disease is:

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

Answer: A

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

NEW QUESTION 118
- (Topic 2)
Which of the following ethnic groups is at highest risk in the United States for pesticide- related injuries?

A. Native American
B. Asian-Pacific
C. Norwegian
D. Hispanic

Answer: D

Explanation:
Because Hispanic people represent a large percentage of migrant workers in the United States, many work in agricultural settings and might be exposed to pesticides, putting them at higher risk than the other groups.Safety and Infection Control

NEW QUESTION 120
- (Topic 2)
What significant event occurs in the orientation phase of a nurse-client relationship?

A. establishment of roles
B. identification of transference phenomenon
C. placement of the client within the client??s family structure
D. client agreement that the nurse has the authority in the relationship

Answer: B

Explanation:
Transference phenomena are intensified in relationships with authority, such as physicians and nurses.
Common positive transferences include desire for affection and gratification of dependency needs. Common negative transferences include hostility and competitiveness. These transferences must be recognized and resolved before growth and positive change can be undertaken in the working stage.
Psychosocial Integrity

NEW QUESTION 125
- (Topic 2)
The most common cause of injury from a house fire is:

A. explosion.
B. falls from second-story windows.
C. thermal damage to skin and body surfaces.
D. inhalation injury.

Answer: D

Explanation:
Inhalation is the most common cause of injury from a house fire.Accident Prevention

NEW QUESTION 130
- (Topic 2)
Which of the following solutions is routinely used to flush an IV device before and after the administration of blood to a client?

A. 0.9% sodium chloride
B. 5% dextrose in water solution
C. sterile water
D. Heparin sodium

Answer: A

Explanation:
Normal saline is 0.9% sodium chloride. This solution has the same osmolarity as blood. Its use does not
cause lysis of cells. Choices 2 and 3 are hypotonic solutions that can cause cell lysis. Choice 4 is an anticoagulant.
Pharmacological Therapies

NEW QUESTION 132
- (Topic 2)
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

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

Answer: C

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

NEW QUESTION 134
- (Topic 2)
How often must physical restraints be released?

A. every 2 hours
B. between 1 and 3 hours
C. every 30 minutes
D. at least every 4 hours

Answer: A

Explanation:
Restraints must be released every 2 hours, and the client must be assessed every 30 minutes while restrained.
Safety and Infection Control

NEW QUESTION 135
- (Topic 2)
A client has chronic respiratory acidosis caused by end-stage chronic obstructive pulmonary disease (COPD). Oxygen is delivered at 1 L/min per nasal cannula. The nurse teaches the family that the reason for this is to avoid respiratory depression, based on which of the following explanations?

A. COPD clients are stimulated to breathe by hypoxia.
B. COPD clients depend on a low carbon dioxide level.
C. COPD clients tend to retain hydrogen ions if they are given high doses of oxygen.
D. COPD clients thrive on a high oxygen level.

Answer: A

Explanation:
COPD clients are compensating for low oxygen and high carbon dioxide levels. Hypoxia is the main stimulus to breathe in persons with chronic hypercapnia. Increasing the level of oxygen decreases the stimulus to breathe.
Physiological Adaptation

NEW QUESTION 136
- (Topic 2)
Mr. H. is upset regarding being in the hospital for another day because he states it costs too much. The rights he is likely to demand include all of the following except:

A. the right to examine and question the bill.
B. the right to reasonable response to requests.
C. the right to refuse treatment.
D. the right to confidentiality.

Answer: D

Explanation:
Confidentiality is the maintenance of privacy of information. The question does not suggest that confidentiality has been breached. The client is likely to demand the other rights and may exercise them in choosing to leave the hospital early.Coordinated Care

NEW QUESTION 139
- (Topic 2)
An elderly client denies that abuse is occurring. Which of the following factors could be a barrier for the client to admit being a victim?

A. knowledge that elder abuse is rare
B. personal belief that abuse is deserved
C. lack of developmentally appropriate screening tools
D. fear of reprisal or further violence if the incident is reported

Answer: D

Explanation:
Barriers to reporting elder abuse include victim shame, fear of reprisals, fear of loss of caregiver, and lack of knowledge of agencies that provide services. Many elders fear that reporting abuse results in their placement in long-term care because the current caregiver is the abuser. Choices 1 and 3 are incorrect. Choice 2 might be true but is not the best choice.Psychosocial Integrity

NEW QUESTION 142
- (Topic 2)
An assessment of the skull of a normal 10-monthold baby should identify which of the following?

A. closure of the posterior fontanel.
B. closure of the anterior fontanel.
C. overlap of cranial bones.
D. ossification of the sutures.

Answer: A

Explanation:
The posterior fontanel should close by the age of 2 months.Health Promotion and Maintenance

NEW QUESTION 143
- (Topic 2)
The focus of a nurse case manager is:

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

Answer: B

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

NEW QUESTION 146
- (Topic 2)
Client self-determination is the primary focus of:

A. malpractice insurance.
B. nursing??s advocacy for clients.
C. confidentiality.
D. health care.

Answer: B

Explanation:
Advocacy for clients by nurses is the primary focus of the client??s right to autonomy and self-determination.
Confidentiality involves the maintenance of the privacy of the client and information regarding him or her.
Malpractice insurance is a type of insurance for professionals.Coordinated Care

NEW QUESTION 151
- (Topic 2)
Several passengers aboard an airliner suddenly become weak and suffer breathing difficulty. The diagnosis is likely to be:

A. outbreak of Asian flu.
B. Chemical exposure.
C. bacterial pneumonia.
D. allergic reaction.

Answer: B

Explanation:
The most likely cause of groups of individuals suddenly experiencing similar signs of illness all at once is a chemical exposure.Safety and Infection Control

NEW QUESTION 155
- (Topic 2)
According to the ANA Code of Ethics for Nurses, professional nurses have an ethical obligation to:

A. clients (patients).
B. the profession of nursing.
C. provide high-quality care.
D. all of the above.

Answer: D

Explanation:
All the choices are elements of the ANA Code of Ethics for Nurses.Coordinated Care

NEW QUESTION 157
- (Topic 2)
Vaccines provide what type of immunity?

A. active
B. passive
C. transplacental
D. active and passive

Answer: A

Explanation:
Vaccines provide active immunity. Passive immunity comes from antibodies produced in another human or
host. Transplacental immunity comes from passive immunity transferred from mother to infant.Health Promotion and Maintenance

NEW QUESTION 162
- (Topic 2)
Medication bound to protein can have which of the following effects?

A. enhancement of drug availability
B. rapid distribution of the drug to receptor sites
C. less availability to produce desired medicinal effects
D. increased metabolism of the drug by the liver

Answer: C

Explanation:
Only an unbound drug can be distributed to active receptor sites. Therefore, the more of a drug that is bound to protein, the less it is available for the desired drug effect. Choice 1 is incorrect because less drug is available if it is bound to protein. Choice 2 is incorrect because distribution to receptor sites is irrelevant if the drug, which is bound to protein, cannot bind with a receptor site. Choice 4 is incorrect because metabolism is not increased. The liver first has to remove the drug from the protein molecule before metabolism can occur.
The protein is then free to return to circulation and be used again.Pharmacological Therapies

NEW QUESTION 165
- (Topic 2)
A syringe pump is a type of electronic infusion pump used to infuse fluids or medications directly from a syringe. This device is commonly used for:

A. solutions administered in obstetrics.
B. dilute antibiotics.
C. large volumes of IV solution.
D. the neonatal and pediatric populations.

Answer: D

Explanation:
Small volumes of medication or fluids are delivered and sometimes at slow rates to neonates and pediatric clients. The syringe pump allows precise infusion of small volumes. Choice 1 is incorrect because a syringe pump can be used in almost any setting, but is not generally for adult clients. Choices 2 and 3 are incorrect because large volumes of fluids are not administered with a syringe pump.Pharmacological Therapies

NEW QUESTION 170
- (Topic 2)
The 24-hour day-night cycle is known as:

A. circadian rhythm.
B. infradium rhythm.
C. ultradian rhythm.
D. non-REM rhythm.

Answer: A

Explanation:
Circadian rhythm is rhythmic repetition of patterns each 24 hours. The other options are incorrect.Basic Care and Comfort

NEW QUESTION 175
- (Topic 2)
On first meeting, a new nurse manager makes eye contact, smiles, initiates conversation about the previous work experience of nurses, and encourages active participation by nurses in the dialogue. Her behavior is an example of:

A. aggressiveness.
B. passive aggressiveness.
C. passiveness.
D. assertiveness.

Answer: D

Explanation:
This nurse manager is demonstrating assertive behavior. Aggressive behavior dominates or embarrasses.
Passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness.
Coordinated Care

NEW QUESTION 179

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

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

Answer: B

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

NEW QUESTION 183
- (Topic 2)
The intent of the Patient Self Determination Act (PSDA) of 1990 is to:

A. enhance personal control over legal care decisions.
B. encourage medical treatment decision making prior to need.
C. give one federal standard for living wills and durable powers of attorney.
D. emphasize client education.

Answer: B

Explanation:
The purpose of the PSDA is to promote decision-making prior to need. Choices 1, 3 and 4 are incorrect. The focus of the PSDA is individual health care decision-making. A federal standard for advance directives does not exist. Each state has jurisdiction regarding these policies and protocols.Coordinated Care

NEW QUESTION 188
- (Topic 2)
Support-system enhancement includes all of the following except:

A. determining the barriers to using support systems.
B. discussing ways to help with others who are concerned.
C. exploring life problems of the support-team members.
D. involving spouse, family, and friends in the care and planning.

Answer: C

Explanation:
The exploration of life problems of support-team members is not necessary to enhance the support system.
Choices 1, 2, and 4 are all enhancements for a support system.Psychosocial Integrity

NEW QUESTION 189
- (Topic 2)
As part of a routine health screening, the nurse notes the play of a 2-year-old child. Which of the following is an example of age-appropriate play at this age?

A. builds towers with several blocks
B. tries to color within the lines
C. says ??Mine!?? when playing with toys
D. tries to jump rope

Answer: C

Explanation:
Toddlers are possessive and struggle for independence. The other play activities are too advanced for a 2-year-old child.Health Promotion and Maintenance

NEW QUESTION 194
- (Topic 2)
A client with massive chest and head injuries is admitted to the ICU from the Emergency Department. All of the following are true except:

A. B.the physician in charge of the case is the only person allowed to decide whether organ donation can occur.
B. C.the client??s legally responsible party may make the decision for organ donation for the donor if the client is unable to do so.
C. D.the organ procurement organization makes the decision regarding which organs to harvest.

Answer: C

Explanation:
The client??s legally responsible party may make the decision for organ donation if the client is unable to do so.
The donor (or legally responsible party for the donor), the physician, and the organ- procurement organization are all involved in the process regarding whether organ donation is appropriate for a specific donor.Coordinated Care

NEW QUESTION 195
- (Topic 3)
When teaching a client about anti-retroviral therapy for human immunodeficiency virus (HIV), the PN should emphasize:

A. when started, therapy must not be interrupted to prevent viral resistance.
B. when started, therapy must not be interrupted to prevent opportunistic infection.
C. therapy should be interrupted for one day each month to prevent toxicity.
D. therapy should be interrupted for one week every three months to prevent toxicity.

Answer: A

Explanation:
HIV mutates very rapidly, and any interruption of therapy can allow viral resistance to emerge—even taking
a dose late. Choice 2 is incorrect because, when the virus is kept in check with anti- retrovirals, the client??s own immune system is able to keep opportunistic infections at bay. Choices 3 and 4 are incorrect because therapy should not be interrupted for any reason. If the client develops toxicity, another anti- retroviral drug might be prescribed.Physiological Adaptation

NEW QUESTION 200
- (Topic 3)
After breast reconstruction secondary to breast cancer, the nurse should recognize which
of the following expected client outcomes as evidence of a favorable response to nursing interventions related to disturbed body image?

A. maintaining adequate tissue perfusion
B. demonstrating behaviors that reduce fears
C. restored body integrity
D. remaining free of infection

Answer: C

Explanation:
A sense of restored body integrity is an expected outcome for interventions related to disturbed body image.
Adequate tissue perfusion is an outcome for risk of injury and risk of infection, not disturbed body image.
Demonstrating behaviors that might reduce fears is an outcome for anxiety. Remaining free of infection is an outcome for risk of infection.Health Promotion and Maintenance

NEW QUESTION 204
- (Topic 3)
A Hispanic client brings her father to the clinic because he is becoming more forgetful. He is diagnosed with Alzheimer??s disease. The woman tells the nurse that she wants to try ginkgo biloba for her father, before using prescription medications. Which of the following is an appropriate response by the nurse?

A. ??It is wiser to start a prescription.??
B. ??That herb won??t do your father any good.??
C. ??You can??t expect an herb to treat Alzheimer??s.??
D. ??I will let the physician know of your wishes.??

Answer: D

Explanation:
The culturally sensitive response is to notify the physician of the family member??s wishes and to determine whether it is feasible. Ginkgo biloba has been shown to be of some benefit in treating dementia. The other statements are not culturally sensitive.Reduction of Risk Potential

NEW QUESTION 209
- (Topic 3)
In teaching bleeding precautions to a client with leukemia, the PN should include which of the following instructions?

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

Answer: A

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

NEW QUESTION 214
- (Topic 3)
A client has a nasogastric (NG) tube in place following abdominal surgery. The purpose of this tube immediately following surgery is to:

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

Answer: C

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

NEW QUESTION 215
- (Topic 3)
Perineal care to a female client by the nurse can be performed:

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

Answer: C

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

NEW QUESTION 220
- (Topic 3)
A client, age 28, is 8 12 months pregnant. She is most likely to display which normal skin- color variation?

A. vitiligo
B. erythema
C. cyanosis
D. chloasma

Answer: D

Explanation:
Chloasma, also known as the mask of pregnancy, is described as tan-to-brown patches on the face. This hyperpigmentation results from hormonal changes.Health Promotion and Maintenance

NEW QUESTION 221
- (Topic 3)
Which of the following statements by an adult child of a client with late-stage Alzheimer??s disease indicates a need for further teaching by the nurse?

A. ??I should provide a regular schedule for toileting.??
B. ??I should talk to my father less because he can??t communicate.??
C. ??I should give my father oral care after every meal and bedtime.??
D. ??I should assist my father with eating and drinking.??

Answer: B

Explanation:
Even though an Alzheimer??s client might not be able to talk or communicate his needs, the family should still communicate through talking and touching. The other statements are correct and indicate adequate understanding.
Reduction of Risk Potential

NEW QUESTION 226
- (Topic 3)
When the nurse is determining the appropriate size of a nasopharyngeal airway to insert, which body part should be measured on the client?

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

Answer: D

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

NEW QUESTION 228
- (Topic 3)
While performing a physical assessment on a 6-month-old infant, the nurse observes head lag. Which of the following nursing actions should the nurse perform first?

A. Ask the parents to allow the infant to lay on her stomach to promote muscle development.
B. Notify the physician because a developmental or neurological evaluation is indicated.
C. Document the findings as normal in the nurse??s notes.
D. Explain to the parents that their child is likely to be mentally retarded.

Answer: B

Explanation:
Head lag should be completely resolved by 4 months of age. Continuing head lag at 6 months of age indicates the need for further developmental or neurological evaluation. Laying the infant on her stomach promotes muscle development of the neck and shoulder muscles, but because of the age of this child, a referral should be the first action. These findings are not normal for a 6-month-old infant. Significant head lag can be seen in infants with Down syndrome and hypoxia, as well as neurologic and other metabolic disorders. Some of those disorders might have mental retardation as a component. However, this child needs to have the referral to determine the cause of the head lag first.Health Promotion and Maintenance

NEW QUESTION 229
- (Topic 3)
Melissa Smith came to the Emergency Department in the last week before her estimated date of confinement complaining of headaches, blurred vision, and vomiting. Suspecting PIH, the nurse should best respond to Melissa??s complaints with which of the following statements?

A. ??The physician will probably want to admit you for observation.??
B. ??The physician will probably order bed rest at home.??
C. ??These are really dangerous signs.??
D. ??The physician will probably prescribe some medicine for you.??

Answer: B

Explanation:
Pregnancy-induced hypertension (PIH) is a hypertensive disorder of pregnancy, developing after 20 weeks gestation. It is characterized by edema, hypertension, and proteinuria (preclampsia and eclampsia). The cause is unknown. The client with advanced PIH needs rest, and home is the best place to get it. Hospitalization is not necessary in this situation. Medication is not indicated.Physiological Adaptation

NEW QUESTION 233
- (Topic 3)
Regardless of their practice area, nurses should be concerned with:

A. all drug-resistant bacteria.
B. microorganisms that are critical.
C. transmission of microorganisms.
D. overprescription of bacteriostatic drugs.

Answer: C

Explanation:
All nurses should be concerned with preventing the transmission of microorganisms to themselves as well as to others. One way to accomplish this goal is by asepsis. Nursing practice focuses on providing a safe and therapeutic environment to protect clients, family members, and health care providers from acquiring infections.
Safety and Infection Control

NEW QUESTION 234
- (Topic 3)
Which physiologic mechanism best describes the function of the sodium-potassium pump?

A. active transport
B. diffusion
C. filtration
D. osmosis

Answer: A

Explanation:
Active transport is a process requiring energy to transport ions against a concentration gradient, as is needed in the sodium-potassium pump. Choices 2, 3, and 4 are other regulatory mechanisms involved in fluid and electrolyte balance.Physiological Adaptation

NEW QUESTION 237
- (Topic 3)
Which of the following describes the stages of domestic violence in an intimate relationship?

A. happiness, crisis, angry outburst, intervention
B. honeymoon period, escalation of stress, outburst, reconciliation
C. acting out and making up
D. peace and calm, angry outburst, peace and calm, denial

Answer: B

Explanation:
A pattern of behavior known as the cycle of abuse has been described in the literature. It involves a honeymoon stage, followed by a buildup of stress, an angry outburst that might involve beating, reconciliation, and another honeymoon phase. Clients who do not receive help are at increased risk of harm, which might include homicide.
Psychosocial Integrity

NEW QUESTION 240
- (Topic 3)
In managing nausea related to Morphine epidural analgesia, the nurse should administer:

A. Indocin
B. Codeine
C. Motrin
D. Compazine

Answer: D

Explanation:
Compazine is the drug that should be administered.Basic Care and Comfort

NEW QUESTION 241
- (Topic 3)
Which of the following statements by a client indicates adequate understanding of preparation for a lipoprotein fractionation test?

A. ??I cannot eat or drink after midnight.??
B. ??I cannot eat for 12 hours before the test.??
C. ??I need to limit my fluid intake.??
D. ??I need to ingest a lipid solution.??

Answer: B

Explanation:
For lipid fractionation, the client cannot eat for 12 hours prior to the test, but he or she can drink an unrestricted amount of water. No lipid solution is given. Thus, the other choices are incorrect.Reduction of Risk Potential

NEW QUESTION 242
- (Topic 3)
Which type of hepatitis is transmitted via the fecal-oral route?

A. A
B. B
C. C
D. D

Answer: A

Explanation:
Type A hepatitis is transmitted via the fecal-oral route. The remaining types have other modes of transmission.
Physiological Adaptation

NEW QUESTION 246
- (Topic 3)
Which of the following tests is commonly performed on newborns with jaundice?

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

Answer: C

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

NEW QUESTION 249
- (Topic 3)
An elevation in which of the following enzymes is indicative of pancreatitis?

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

Answer: D

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

NEW QUESTION 254
- (Topic 3)
Which of the following coping mechanisms protects an individual from anxiety?

A. denial and fantasy
B. rationalization and suppression
C. regression and displacement
D. reaction formation and projection

Answer: A

Explanation:
Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety.
Psychosocial Integrity

NEW QUESTION 255
- (Topic 3)
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

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

Answer: C

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

NEW QUESTION 257
- (Topic 3)
Pressure ulcers usually occur:

A. when clients are left in one position in bed for extended periods of time.
B. when clients are underweight.
C. when clients are overweight.
D. only in underweight and overweight clients.

Answer: A

Explanation:
Pressure ulcers usually occur over bony prominences and are caused by decreased circulation. The client who is left in one position in bed for extended periods of time is more prone to decreased circulation to an area of the body and to acquiring a pressure ulcer.Basic Care and Comfort

NEW QUESTION 260
- (Topic 3)
Which of the following foods present a problem for a client diagnosed with Celiac Disease?

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

Answer: B

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

NEW QUESTION 261
- (Topic 3)
When suctioning a client, what is the usual amount of time the nurse should spend for each suction pass?

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

Answer: B

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

NEW QUESTION 265
- (Topic 3)
When a client who is having trouble conceiving says to the nurse, ??I have started taking ginseng,?? the best response by the nurse is:

A. ??No studies show that ginseng is effective for infertility.??
B. ??Some studies show that ginseng enhances in vitro sperm motility.??
C. ??Why don??t you try acupuncture instea
D. Many studies have shown it to be effective for infertility.??
E. ??It??s probably not going to hurt you, but it??s also probably not going to hel
F. Let??s look at some other alternatives.??

Answer: B

Explanation:
Some studies have shown that ginseng and astragalus have enhanced in vitro sperm motility. Ginseng has long been used in traditional Chinese medicine to enhance male fertility. So, Choice 2 is correct and directly addresses the client??s comments. Many times couples struggling with infertility turn to alternative therapies in desperation. They can be very expensive, and some are harmful. Ginseng should not interfere with any of the traditional fertility treatments and might help the couple feel empowered that they are also doing something on their own. Choice 1 is not true. Choice 3 introduces another alternative therapy. It is true that acupuncture is a traditional Chinese medical therapy and has been shown in several clinical studies to be effective in treating infertility in both women and men. The best response by the nurse should address the therapy the client states she is using. Choice 4 dismisses the client??s attempts to work through her issues and contribute to the solution. One concern is always that more traditional therapies might be ignored, and time might be lost to alternative therapies. But this response causes the client to perceive the nurse as unsupportive and inhibits further discussion and disclosure.Health Promotion and Maintenance

NEW QUESTION 266
- (Topic 3)
Laboratory tests reveal the following electrolyte values for Mr. Smith: Na 135 mEq/L, Ca 8.5 mg/dL, Cl 102 mEq/L, and K 2.0 mEq/L. Which of the following values should the nurse report to the physician because of its potential risk to the client?

A. Ca
B. K
C. Na
D. Cl

Answer: B

Explanation:
Normal serum potassium level ranges between 3.5 and 5.5 mEq/L. The levels in choices 1, 3, and 4 are within normal ranges.Physiological Adaptation

NEW QUESTION 269
- (Topic 3)
A client with a nasogastric (NG) tube begins vomiting. What action should the nurse take?

A. Retape the NG tube.
B. Clamp the NG tube.
C. Remove the NG tube.
D. Check the NG tube placement.

Answer: D

Explanation:
For the client with an NG tube who begins vomiting, the nurse should check the tube placement because it might be displaced, thereby leading to vomiting. The other responses are not appropriate.
Reduction of Risk Potential

NEW QUESTION 270
- (Topic 3)
A pregnant client has congenital heart disease. The nurse should expect to see which alterations in this client??s diet during pregnancy?

A. reduced calories and reduced fat
B. caffeine and sodium restrictions
C. decreased protein and increased complex carbohydrates
D. fluid restriction and reduced calories

Answer: B

Explanation:
Caffeine might increase heart rate that is already stressed due to pregnancy. Sodium can cause fluid retention. Both might need to be restricted. The other choices are incorrect because calories, fat, and protein are not usually decreased due to the risk of nutrient deficiencies.Basic Care and Comfort

NEW QUESTION 271
- (Topic 3)
A client had a colostomy done one day ago. Which of the following is an abnormal finding when assessing the stoma?

A. mild edema
B. minimal bleeding
C. rose color
D. dark red color

Answer: D

Explanation:

A dark red color is an abnormal finding when assessing the stoma. It indicates inadequate blood supply. The other findings are normal one day postoperatively.Physiological Adaptation

NEW QUESTION 276
- (Topic 3)
A Roman Catholic client is preparing to have magnetic resonance imaging. He wants to wear his metal crucifix pendant while he is receiving the test. Which of the following is an appropriate response by the nurse?

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

Answer: C

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

NEW QUESTION 281
- (Topic 3)
Which of the following is a predisposing factor for cancer of the tongue?

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

Answer: A

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

NEW QUESTION 282
- (Topic 3)
The nurse who was not promoted then went to the utility room and slammed several cupboard doors while looking for Kleenex. This behavior exemplifies:

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

Answer: A

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

NEW QUESTION 285
- (Topic 3)
Which of the following is the most appropriate diet for a client who is unable to swallow?

A. nothing by mouth
B. nasogastric feedings
C. clear liquids
D. total parenteral nutrition

Answer: B

Explanation:
Nasogastric feedings are most appropriate for a client who is unable to swallow. Nothing by mouth leads to
nutritional deficiencies. The client might aspirate a clear liquid diet. TPN is not necessary as long as the gut is still functioning.Reduction of Risk Potential

NEW QUESTION 287
- (Topic 3)
A hospital discharge planning nurse is making arrangements for a client who has an epidural catheter for continuous infusion of opioids to be placed in a long-term care facility. The family prefers a facility in its neighborhood to facilitate visiting. The neighborhood facility has never cared for a client with this type of need. What is the most appropriate action by the discharge planning nurse?

A. B.Arrange for immediate in-services for the long-term care facility staff on pain management using epidural catheters.
B. C.Explain the situation to the client and family and seek another long-term care facility for discharge from the hospital.
C. D.Encourage the family to hire private duty nurses skilled in epidural catheter pain management to allow the client to be transferred to the neighborhood facility.

Answer:

C

Explanation:
Safety demands that a client be transferred to a facility that can deliver care equal to the hospital.Basic Care and Comfort

NEW QUESTION 288
- (Topic 3)
When caring for a client with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?

A. perineal shave
B. enema
C. urine specimen collection
D. blood specimen collection

Answer: B

Explanation:
An enema could dislodge the placenta and increase bleeding.Physiological Adaptation

NEW QUESTION 290
- (Topic 3)
Which of the following strategies should the nurse include when planning care for children of migrant workers?

A. Delay immunization because of acute illness.
B. Provide parents with copies of medical records.
C. Schedule preventive services at acute illness visits.
D. Stress the importance of using one primary care provider.

Answer: B

Explanation:
Migrant workers should be provided with the medical records and immunization records for their children, including growth charts. The parents should also be encouraged to take those records with them to every health care visit, including Emergency Department visits. It is important to provide immunizations even when the child is there for an acute illness because preventive care is often not obtained. Preventive services should also be provided, not scheduled, when a child presents for an acute illness. Using a single primary care provider is not an option for most migrant families. The nurse should ask the parents about where they are going next and give them the name, address, and phone numbers of providers there.Health Promotion and Maintenance

NEW QUESTION 293
- (Topic 3)
Distraction therapy is:

A. focusing one??s attention on stimuli other than pain.
B. cognitive reappraisal.
C. the replacement of positive images of pain with other images.
D. the use of medication and meditation.

Answer: A

Explanation:
The focus of distraction therapy is on positive stimuli rather than negative input.Basic Care and Comfort

NEW QUESTION 297
- (Topic 3)
Milieu therapy is best employed to perform which activity?

A. investigating the client??s view of the world
B. promoting socialization skills
C. focusing on inappropriate behavior
D. providing repetitive ordinary experiences on a daily basis

Answer: D

Explanation:
Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by
minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.Psychosocial Integrity

NEW QUESTION 302
- (Topic 4)
When assessing a client with early impairment of oxygen perfusion, such as pulmonary embolus, the nurse should expect to find restlessness and which of the following symptoms?

A. warm, dry skin
B. bradychardia
C. tachycardia
D. eupnea

Answer: C

Explanation:
The cardinal signs of respiratory problems and hypoxia are restlessness, diaphoresis, tachycardia, and cool skin.
Bradycardia might occur much later in the process when the condition is severe. Eupnea is normal respirations in rate and depth.Physiological Adaptation

NEW QUESTION 304
- (Topic 4)
A 50 milliliter (ml) bolus of normal saline fluid is ordered by the physician. The physician wants it to infuse in 30 minutes. The nurse should set the pump rate at:

A. 100 ml per hour for one hour.
B. 60 ml per hour for one-half hour.
C. 120 ml per hour for one hour.
D. 50 ml per hour for one hour.

Answer: A

Explanation:
One hundred ml in one hour equals 50 ml in 30 minutes, which is what the physician prescribed. Choice 2 is 10 ml more than the physician prescribed for 30 minutes. Choice 3 is the same asChoice 2; it is 10 ml more than the physician prescribed for 30 minutes. Choice 4 only provides 25 ml over 30 minutes, or half the volume prescribed. Pharmacological Therapies

NEW QUESTION 308
- (Topic 4)
Referral for client education in the community can be accomplished through all of the following except:

A. community agencies such as the American Heart Association.
B. parish nurses.
C. home health care agencies.
D. unlicensed massage therapists.

Answer: D

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

NEW QUESTION 311
- (Topic 4)
Mrs. Peterson complains of difficulty falling asleep, awakening earlier than desired, and not feeling rested. She attributes these problems to leg pain that is secondary to her arthritis. What is the most appropriate nursing diagnosis for her?

A. Sleep Pattern Disturbances (related to arthritis)
B. Fatigue (related to leg pain)
C. Knowledge Deficit (regarding sleep hygiene measures)
D. Sleep Pattern Disturbances (related to chronic leg pain)

Answer: D

Explanation:
The client??s sleep pattern is directly disturbed by the chronic leg pain, which is secondary to the arthritis. This nursing diagnosis is the appropriate one to directly deal with comfort measures and the like.Basic Care and Comfort

NEW QUESTION 316
- (Topic 4)
There are many types of torts that can be committed against clients. They include all of the following except:

A. assault.
B. battery.
C. negligence.
D. felony.

Answer: D

Explanation:
Felonies are serious crimes punishable by time in prison. Types of torts are assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.Coordinated Care

NEW QUESTION 318
- (Topic 4)
When a client has a chest drainage system in place, where should the system be placed?

A. above the client??s head
B. at the client??s shoulders
C. at the level of the chest
D. below the level of the chest

Answer: D

Explanation:
A chest drainage system should be placed below the level of the client??s chest so that the drainage flows out of the chest into the system. The remaining choices are too high and do not allow fluid to drain out of the chest.Reduction of Risk Potential

NEW QUESTION 319
- (Topic 4)
Who should receive the hepatitis A vaccine?

A. children who are 18 months of age
B. infants, who should receive the vaccination at birth
C. people who travel to other countries
D. individuals who might come into contact with blood

Answer: C

Explanation:
Hepatitis A is for individuals who travel or persons with chronic liver disease. Infants receive the hepatitis B vaccine at birth. DTaP is administered at 18 months of age. Individuals who come into contact with blood should be immunized against hepatitis B. Health Promotion and Maintenance

NEW QUESTION 323
- (Topic 4)
The physician??s role in case management includes all of the following except:

A. participating in interdisciplinary planning for clients.
B. serving as the expert for resource utilization.
C. consulting with the case management team to facilitate timely orders as needed.
D. contributing to the documentation of a client??s needs for services.

Answer: B

Explanation:
The physician is an integral part of the case-management process in terms of assisting with defining the
client??s needs and the time frames for movement through the health care system; however, the physician is the expert for medical diagnosis and treatment rather than resource utilization.Coordinated Care

NEW QUESTION 325
- (Topic 4)
Some drugs are excreted into bile and delivered to the intestines. Prior to elimination from the body, the drug might be absorbed. This process is known as:

A. hepatic clearance.
B. total clearance.
C. enterohepatic cycling.
D. first-pass effect.

Answer: C

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

NEW QUESTION 327
- (Topic 4)
The nurse is teaching a client about sleep and gives background information on normal sleep patterns. Which of the following substances promotes sleep?

A. serotonin
B. cortisone
C. alcohol
D. narcotics

Answer: A

Explanation:
Serotonin is a substance that is in the body and promotes sleep. Serotonin might play a role in synthesis of a hypnogenic factor that directly causes sleep. Drugs and alcohol can disrupt REM sleep, although they might accelerate the onset of sleep.Basic Care and Comfort

NEW QUESTION 330
- (Topic 4)
Carrying a donor card for organ donation means that:

A. medical care is altered in the event of serious injuries to get organs for donation.
B. the family or legally responsible party of a client has no decision-making authority in the event that the client is considered for organ donation.
C. a client is allowed to revoke his decision for organ donation at any time.
D. a client is considered an organ donor for only one organ or tissue.

Answer: C

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

NEW QUESTION 331
- (Topic 4)
The nurse can best communicate to a client that he or she has been listening by:

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

Answer: A

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

NEW QUESTION 332
- (Topic 4)
A client asks the nurse if all donor blood products are cross-matched with the recipient to prevent a transfusion reaction. Which of the following always requires cross-matching?

A. packed red blood cells
B. platelets
C. plasma
D. granulocytes

Answer: A

Explanation:
Packed red blood cells contain antigens and antibodies that must be matched between donor and recipient. Choices 2, 3, and 4 do not contain red cells; thus, they require no cross-matching.Pharmacological Therapies

NEW QUESTION 336
- (Topic 4)
The primary organ for drug elimination is the:

A. skin.
B. lung(s).
C. kidney(s).
D. liver.

Answer: C

Explanation:
Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.PharmacologicalTherapies

NEW QUESTION 341
- (Topic 4)
The nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse??s next action should be to:

A. do nothing; the client has the right to refuse treatment.
B. report the incident to the police.
C. arrange an appointment with the client??s next of kin.
D. educate the client about available services.

Answer: D

Explanation:
Although clients do have the right to refuse treatment, the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.Psychosocial Integrity

NEW QUESTION 345
- (Topic 4)
A client with a diagnosis of Schizophrenia has been released from an acute care setting. The client had a prolonged recovery from relapse. One of the parents says to the discharge nurse, ??I do not understand what is going on. The hospital said she was better, but all she does is sit around all day and smoke. We cannot get her to go to the vocational training you arranged.?? The nurse recognizes that more teaching is needed about:

A. the pathophysiology and acting out behaviors of schizophrenia.
B. support groups that can help the parents release their feelings of frustration.

C. the prolonged recovery time and depressive effects of medicines to prevent relapse.
D. motivational techniques that are effective in clients with schizophrenia.

Answer: C

Explanation:
The nurse conducting discharge teaching must stress the lengthy recuperation process with emphasis on the sedative qualities of the medication used to prevent relapse. Support groups are useful for caregivers. The emphasis during recuperation is on maintaining nutrition and hygiene.Psychosocial Integrity

NEW QUESTION 350
- (Topic 4)
Which of the following clients require airborne precautions?

A. a client with fever, chills, vomiting, and diarrhea
B. a client suspected of varicella (chickenpox)
C. a client with abdominal pain and purpura
D. a client diagnosed with AIDS

Answer: B

Explanation:
Chickenpox (varicella) is an acute, infectious, airborne illness that requires others in direct contact to wear a respirator mask.Safety and Infection Control

NEW QUESTION 354
- (Topic 4)
All of the following tasks could be delegated to a nursing assistant or unlicensed assistive personnel (UAP) except:

A. monitoring intravenous infusion.
B. assisting a client to the bathroom.
C. offering fluid intake every 1–2 hours.
D. monitoring/recording the amount of fluid taken.

Answer: A

Explanation:
Monitoring an intravenous infusion must be performed by an RN or LPN. Assisting during activity, offering fluids and recording intake are in the job scope of the nursing assistant. Coordinated Care

NEW QUESTION 357
- (Topic 4)
What is the reason for a contract between nurse and client?

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

Answer: D

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

NEW QUESTION 361
- (Topic 4)
The nurse acts as an advocate for the nursing profession by performing all of the following activities except:

A. encouraging political involvement by nurses with their legislators.
B. acting as a first-aid provider for a children??s athletic team.
C. precepting newly licensed nurses in the work situation.
D. encouraging as many persons to become nurses as possible.

Answer: D

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

NEW QUESTION 362
- (Topic 4)
An example of an extended care facility is a:

A. home health agency.
B. suicide prevention center.
C. state-owned psychiatric hospital.
D. nursing facility.

Answer: D

Explanation:
When an elderly client has been hospitalized for an illness, under Medicare he or she can be transferred to a nursing facility.Health Promotion and Maintenance

NEW QUESTION 365
- (Topic 4)
The nurse is working with families who have been displaced by a fire in an apartment complex. What is the priority intervention during the initial assessment?

A. Provide a liaison to meet housing needs.
B. Attentively listen when clients describe their feelings.
C. Offer nurturing support for clients who are confused by the events.
D. Provide structure for clients exhibiting moderate to severe anxiety.

Answer: A

Explanation:
After physical needs of housing, clothing and food are met, the nurse should focus on assisting clients to manage the psychological effects of loss.Psychosocial Integrity

NEW QUESTION 369
- (Topic 4)
The advanced directive in a client??s chart is dated August 12, 1998.The client??s daughter produces a Power of Attorney for Health Care, dated 2003, which contains different care direction(s). The nurse is supposed to:

A. follow the 1998 version because it??s part of the legal chart.
B. follow the 1998 version because the physician??s code order is based on it.
C. follow the 2003 version, place it in the chart, and communicate the update appropriately.
D. follow neither until clarified by the unitmanager.

Answer: C

Explanation:
The document dated 2003 supersedes the previous version and should be used as a basis for care direction.
Choices 1 and 2 are incorrect because the 1998 version is now outdated. Choice 4 is incorrect because the nurse can be held negligent for not responding to the 2003 document as directed.Coordinated Care

NEW QUESTION 372
- (Topic 4)
The nurse and a colleague are on the elevator after their shift, and they hear a group of health caregivers discussing a recent client scenario. Which client right might be breached?

A. right to refuse treatment
B. right to continuity of care
C. right to confidentiality
D. right to reasonable responses to requests

Answer: C

Explanation:
The right to confidentiality of client information might be breached when client care situations are discussed in public areas or without regard to maintaining the information as private and confidential. The other rights listed have not been breached in this instance. Coordinated Care

NEW QUESTION 375
- (Topic 4)
Kleinman??s Explanatory Model of Health and Illness is significant because:

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

Answer: C

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

NEW QUESTION 376
- (Topic 4)
A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

A. pain on movement and weight bearing
B. hemorrhage
C. affected leg appearing 1–2 inches longer
D. edema in the area of the incision

Answer: A

Explanation:
Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation. Other symptoms of dislocation include an inability to bear weight and a shortening of the affected leg. Edema is not a primary sign of displacement.Physiological Adaptation

NEW QUESTION 377
- (Topic 4)
A complication of total parenteral nutrition (TPN) is the development of cholestasis. What is this condition?

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

Answer: B

Explanation:
Cholestasis due to TPN administration is an intrahepatic process that interrupts the normal flow of bile. Extrahepatic bile duct inflammation is cholangitis. Inflammation of the gallbladder is cholecystitis. Gallstones are formed by bile components.Pharmacological Therapies

NEW QUESTION 381
- (Topic 4)
A client has sustained a hyphema. What intervention should the nurse take?

A. Have the client wear ear protectors in the future.
B. Keep the client at bed rest, typically with the head of the bed propped up.
C. Apply atropine eye drops.
D. Apply an ice pack to the site of injury.

Answer: B

Explanation:
Initial care of the client involves preventing further damage and rebleeding. Clients are kept at bed rest if possible, usually with the head of the bed raised. TV watching is permitted but not reading. The use of atropine, ice, and eye shields are controversial, and a nurse should not administer a pharmacologic agent or thermal therapy without a physician??s order. Safety and Infection Control

NEW QUESTION 385
- (Topic 4)
The nurse is caring for a dying client who has persistently requested that the nurse ??help her to die and be in peace.?? According to the Code of Ethics for Nurses, the nurse should:

A. Ask the client whether she has signed the advance directives document.
B. Tell the client that he or she will ask another nurse to care for her.
C. Instruct the client that only a physician can legally assist a suicide.
D. Try to make the client as comfortable as possible, but refuse to assist in death.

Answer: D

Explanation:
Try to make the client as comfortable as possible but refuse to assist in death. One of the competencies necessary for nurses to have in giving high quality care to clients/families during the end of life care is: apply legal and ethical principles in the analysis of complex issues and end-of-life care, recognizing the influence of personal values, profession codes, and client preferences.Psychosocial Integrity

NEW QUESTION 388
- (Topic 4)
The emergency triage nurse should perform which action upon receiving the history that a client has a severe cough, fever, night sweats, and body wasting?

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

Answer: B

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

NEW QUESTION 393
- (Topic 4)
While walking in the hallway of an acute care unit of the hospital, the nurse overhears the change of shift report. The nurse should:

A. make the charge nurse on the unit aware of the situation so that he or she can take the necessary steps to maintain the confidentiality of the information being reported.
B. disregard the information because it changes quickly on the acute care unit and is outdated within 2–3 hours anyway.

C. return to his or her own unit and not disclose that confidential information has been overheard.
D. ignore the situation.

Answer: A

Explanation:
To protect the confidentiality of the information being reported, the nurse should make the charge nurse on the unit aware of the situation so that the information can be communicated in an appropriate way in privacy.
Coordinated Care

NEW QUESTION 398
- (Topic 4)
A community health nurse is asked to organize a health promotion project that plans to provide glucose screening. This activity is most beneficial within what realm?

A. testing that is performed by volunteers at a local department store and is open to the public
B. at a professional health fair activity available for selected persons who have been screened as being at risk
C. mass-marketing vouchers for free fingersticks at a local drug store, where the pharmacist makes recommendations on the findings
D. testing that is performed by a nurse professional, who immediately provides education regarding the findings

Answer: B

Explanation:
Public glucose screening has been found to be an ineffective way to screen for diabetes unless based on health risk screening for those persons identified to be at risk or displaying symptoms.Safety and InfectionControl

NEW QUESTION 403
- (Topic 4)
A woman is in the active phase of labor. An external monitor has been applied, and a fetal heart deceleration of uniform shape is observed, beginning just as the contraction is under way and returning to the baseline at the end of the contraction. Which of the following nursing actions is most appropriate?

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

Answer: D

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

NEW QUESTION 408
- (Topic 5)
Which of the following blood pressure parameters indicates PIH? Elevation over a baseline of:

A. 30 mmHg systolic and/or 15 mmHg diastolic.
B. 40 mmHg systolic and/or 20 mmHg diastolic.
C. 10 mmHg systolic and/or 5 mmHg diastolic.
D. 20 mmHg systolic and/or 20 mmHg diastolic.

Answer: A

Explanation:
These are the accepted parameters for mild PIH. Mild preclampsia includes an increase in systolic blood pressure higher than 30 mmHg or an increase in diastolic blood pressure higher than 15 mmHg, noted on two readings taken 6 hours apart (or 140/90). Physiological Adaptation

NEW QUESTION 410
- (Topic 5)
After 12 months of cessation of menses, which of the following assessment findings in a client who is taking hormone replacement therapy should the nurse report to the physician immediately?

A. breast tenderness
B. weight gain
C. fluid retention
D. uterine bleeding

Answer: D

Explanation:
Uterine bleeding on combination hormone replacement therapy, after 12 months of menses cessation, indicates an increased risk of carcinoma and should be reported to the physician immediately. Breast tenderness, weight gain, and fluid retention are all routine side effects ofhormone replacement therapy. They should be noted in the record and reported to the physician, but they are not urgent.Health Promotion and Maintenance

NEW QUESTION 414
- (Topic 5)
What is pica?

A. dependency on alcohol
B. increased iron in the diet
C. the sickle cell trait
D. eating ice

Answer: D

Explanation:
Pica represents the ingestion of nonfood substances that leads to a clinical iron deficiency and might actually be the first sign of a problem. Clients eat a wide range of nonfood items, including ice, clay, dirt, and paste.Physiological Adaptation

NEW QUESTION 418
- (Topic 5)
Which of the following statements by a client indicates adequate preparation for magnetic resonance imaging?

A. ??I can leave my metal jewelry on during the test.??
B. ??I need to wear earplugs during the test.??
C. ??I can have the test even though I have a pacemaker.??
D. ??I can have the test even though I have an artificial hip.??

Answer: B

Explanation:
Due to the loud noises from the scanner moving to obtain images, earplugs need to be worn. No metal objects are allowed, including jewelry, pacemakers, and artificial joints. Reduction of Risk Potential

NEW QUESTION 423
- (Topic 5)
Which of the following infant behaviors demonstrates the concept of object permanence?

A. The infant cries when his mother leaves the room.
B. The infant looks at the floor to find a toy that he was playing with and dropped.
C. The infant picks up another toy after the one he was playing with rolls under the couch.
D. The infant participates in a game of patty-cake.

Answer: B

Explanation:
Object permanence occurs when the infant learns that something/someone still exists even though they might not be able to see it/them. This develops between 9 and 10 months of age. If the infant cries when his mother leaves the room, it might be because he believes she is no longer in the house when he can??t see her. If an infant picks up another toy after the one he is playing with rolls under the couch and the infant fails to look for it, he believes the toy that rolled under the couch no longer exists. Patty-cake is a game infants engage in but, it has nothing to do with object permanence. An infant game that does show object permanence is peek-a-boo. In thisgame, an infant continues to hunt for a hidden face because he believes it is still there.Health Promotion andMaintenance

NEW QUESTION 425
- (Topic 5)
What are the implications for a client with renal insufficiency who wants to start a low- carbohydrate (CHO) diet?

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

Answer: B

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

NEW QUESTION 430
- (Topic 5)
In administering NSAID adjunctive therapy to an elderly client with cancer, the nurse must monitor:

A. BUN and creatinine.
B. creatinine and calcium.
C. Hgb and Hct.
D. BUN and CFT.

Answer: A

Explanation:
Elder adults might be more at risk for gastric and renal toxicity, increasing among elder adults.Basic Care

and Comfort

NEW QUESTION 432
- (Topic 5)
The nurse should make which of the following responses when questioned by a client about the role of leptin in the body?

A. It increases food intake in clients, thereby promoting obesity.
B. It assists in the regulation of steroids.
C. It increases the total fat mass of people who are obese.
D. It might decrease the total fat mass in the bodies of people who are obese.

Answer: D

Explanation:
Leptin (recessive obesity gene—protein hormone) is expressed in fat cell coding for the protein that reacts to the percentage of fat cells in the body. Leptin is associated with increased energy expenditure and decreased food intake via hypothalamic control. Obese clients might have insensitivity or resistance to the effects of leptin. Leptin can affect other body hormones such as insulin. Genetic factors include leptin, uncoupling proteins, and the amount of brown/white fat in the body.Physiological Adaptation

NEW QUESTION 437
- (Topic 5)
The hydraulic lift (Hoyer lift) is:

A. used for all clients who??ve had orthopedic surgery.
B. used for all clients who are not able to stand and for extremity obese clients.
C. used for all clients, both old and young, in a hospital setting.
D. not an assistive device for special needs.

Answer: B

Explanation:
The hydraulic lift is used for safe transfer when a client is not able to stand or is too heavy for the health care workers to lift safely.Basic Care and Comfort

NEW QUESTION 438
- (Topic 5)
In infants and children, the side effects of firstgeneration over-the counter (OTC) antihistamines, such as diphenhydramine (Benedryl) and hydroxyzine (Atarax), can include:

A. Reye??s syndrome.
B. cholinergic effects.
C. paradoxical CNS stimulation.
D. nausea and diarrhea.

Answer: C

Explanation:
Typically, first-generation OTC antihistamines have a sedating effect because of passage into the CNS. However, in some individuals, especially infants and children, paradoxical CNS stimulation occurs and is manifested by excitement, euphoria, restlessness, and confusion. For this reason, use of first-generation OTC antihistamines has declined and second-generation product use has increased. Reye??s syndrome is a systemic response to a virus. First-generation OTC antihistamines do not exhibit a cholinergic effect. Nausea and diarrhea are uncommon with first-generation OTC antihistamines.Pharmacological Therapies

NEW QUESTION 441
- (Topic 5)
When a middle-age woman says to the nurse, ??I??m really worried about menopause. When my mom went through it, she got really depressed.?? The nurse??s best response is:

A. ??It is a myth that women get depressed because of menopause.??
B. ??Menopause is a normal developmental process.??
C. ??It sounds like you are worried that you might become depressed during menopause.??
D. ??When women experience depression during menopause it is usually because of social stresses.??

Answer: C

Explanation:
Choice 3 not only acknowledges the client??s fear but invites more disclosure and discussion. Reflective listening is very therapeutic and in this case acknowledges the woman??s unspoken fear that she might become depressed like her mother. When her fears have been acknowledged and she feels that the nurse understands, she will be more open to the teaching or interventions to follow. It is a myth that menopause causes depression, but to say that to this client does not acknowledge the fear she shared with the nurse and gives the impression the nurse doesn??t care about her concern. It closes down communication. It is also true that menopause is a normal developmental process. This can certainly be used in teaching but not to address her immediate concern; the client might feel the nurse doesn??t think her concern is appropriate because menopause is normal. If women experience depression during menopause, it is usually due to social stresses such as loss of loved ones, loss of roles, caregiver demands, and physical problems. Choice 4 is true but is a nontherapeutic response in this situation.Health Promotion and Maintenance

NEW QUESTION 443
- (Topic 5)
Which of the following statements indicates adequate dietary understanding in a client with constipation?

A. ??I should decrease my intake of fluids.??

B. ??I should decrease my level of activity.??
C. ??I should increase my intake of apples.??
D. ??I should increase my intake of milk.??

Answer: C

Explanation:
Apples are a source of high fiber, which decreases constipation. A constipated client needs to increase fluids and activity level. Milk is not a high-fiber food.Reduction of Risk Potential

NEW QUESTION 447
- (Topic 5)
Which type of diet should the nurse provide to help a client who has major burns maintain a positive nitrogen balance?

A. high protein
B. high carbohydrate
C. low carbohydrate
D. low protein

Answer: A

Explanation:
Clients with burns are hypermetabolic and require increased protein levels to maintain a positive nitrogen balance. Choices 2 and 3 are incorrect; carbohydrate levels do not help clients to meet this goal. Choice 4 is incorrect; a client with major burns requires a high- protein diet.Basic Care and Comfort

NEW QUESTION 451
- (Topic 5)
For a client requiring total oral care, it is important for the nurse to:

A. assemble all equipment, assist the client tosemi-Fowler??s position, and place a towel on his chest.
B. place client in Fowler??s position, prepare the equipment, and tell the client what to do.
C. assemble all equipment, place the client in a side-lying position, and place a towel under his chin.
D. use gloves and clean the client??s mouth, including the tongue.

Answer: C

Explanation:
Assemble all equipment first; place the client in a side-lying position so that fluid can easily flow out or pool in the side of the mouth for suctioning (to prevent aspiration); and then place a towel under the client??s chin and a curved basin against the chin. Gloves should be worn.Basic Care and Comfort

NEW QUESTION 455
- (Topic 5)
Which cultural group has the highest incidence of inflammatory bowel disease (IBD)?

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

Answer: B

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

NEW QUESTION 458
- (Topic 5)
What does client and family communication and education concerning restraints do?

A. confuses both groups more
B. helps with coping and stress levels
C. encourages cooperation with the client and family
D. puts the responsibility on the client and family, not the nurse

Answer: C

Explanation:
Cooperation is more likely if the client and family understand the purpose of and expected gains from restraints.
Well-meaning family members might release restraints if their purpose is not clear.Safety and Infection Control

NEW QUESTION 461
- (Topic 5)
The teaching plan for a postpartum client who is about to be discharged should include which of the following instructions?

A. ??It is normal for your breasts to be tende
B. You should call the physician if you also have redness and fatigue.??
C. ??Because your baby was delivered vaginally, you might have to urinate more frequently.??
D. ??It is normal to run a low-grade temperature for a few day

E. If it is higher than 100?? F, call your physician.??
F. ??Be sure to call your physician if your vaginal discharge becomes bright red.??

Answer: D

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

NEW QUESTION 465
- (Topic 5)
A female client complains to the nurse at the health department that she has fatigue, shortness of breath, and lightheadedness. Her history reveals no significant medical problems. She states that she is always on a fad diet without any vitamin supplements. Which tests should the nurse expect the client to have first?

A. peptic ulcer studies
B. complete blood count, including hematocrit and hemoglobin
C. genetic testing
D. hemoglobin electrophoresis

Answer: B

Explanation:
The initial tests to determine the basis for her symptoms (considering her fad dieting) should be a complete blood count, urinalysis, blood sugar, and other tests. The decision about further testing is then made based on these results, her history, and other factors. Physiological Adaptation

NEW QUESTION 467
- (Topic 5)
In alcoholics with anemia:

A. pernicious anemia is more common than folic acid deficiency.
B. iron deficiency and folic acid deficiency can coexist.
C. the alcohol interferes with iron absorption.
D. oral vitamin replacement is contraindicated.

Answer: B

Explanation:
The ingestion of nonfood substances (alcohol) can lead to a clinical iron deficiency and might actually be the first sign of a problem. The client might substitute alcohol for a nutrition program that fosters a positive health habit.Physiological Adaptation

NEW QUESTION 469
- (Topic 5)
Which type of exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence?

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

Answer: A

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

NEW QUESTION 470
- (Topic 5)
A nurse is caring for a client with an elevated cortisol level. The nurse can expect the client to exhibit symptoms of:

A. urinary excess.
B. hyperpituitarism.
C. urinary deficit.
D. hyperthyroidism.

Answer: C

Explanation:
High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.Physiological Adaptation

NEW QUESTION 472
- (Topic 5)
When discussing possible complications of pregnancy with a client, the nurse should explain that all of the following are symptoms of urinary tract infection (UTI). Which of the following is least indicative of UTI during pregnancy?

A. low-back pain
B. urinary frequency
C. GI distress
D. malaise

Answer: B

Explanation:
Urinary frequency is least indicative of UTI during pregnancy because it is a common minor discomfort of pregnancy and is caused by pressure of the growing uterus on the bladder. As the uterus rises in the second trimester, there are no problems. Frequency returns in the third trimester when the uterus drops into the pelvic cavity. A UTI has the symptoms of frequency, back pain, supra pubic discomfort, and malaise and is diagnosed by laboratory findings.Physiological Adaptation

NEW QUESTION 474
- (Topic 5)
Which of the following statements describes the purpose of client restraint?

A. Restraints are a nursing measure used to maintain client control.
B. Restraints are an emergency intervention taken as a last resort to protect a client from imminent danger.
C. Restraints are a therapeutic measure designed to positively reinforce client behavior.
D. Restraints are an emergency measure that can only be taken by a nurse under the direct supervision of a physician.

Answer: B

Explanation:
The use of restraints as an emergency measure is taken primarily as a last resort to protect a client from harm. Typically, the nurse acts under a physician??s order, but in an emergency, the nurse may restrain a client out of necessity for one hour prior to the client being seen by a physician or an advanced practice mental health provider.Safety and Infection Control

NEW QUESTION 475
- (Topic 5)
When a client who is 25 years of age asks the nurse when she should seek fertility counseling, the best response by the nurse is:

A. ??Fertility counseling should be sought when you have been unable to conceive after 1 year of unprotected intercourse.??
B. ??Fertility couseling should be sought when you have not been able to conceive after 6–9 months of unprotected intercourse.??
C. ??The average time it takes someone your age to conceive is 512 months, so if you haven??t conceived by then, we can refer you.??
D. ??We can give you some guidance now on how to increase your chances of conceiving and then refer you if it doesn??t happen within a year.??

Answer: D

Explanation:
The guidelines for a fertility workup are to refer after the couple has not conceived after one year of unprotected intercourse. So, Choice 1 is technically correct, but it doesn??t consider the immediate need for the couple to have some counseling. Choice 4 is the best answer because it gives the couple guidance now and the referral at the appropriate time. If the woman is over the age of 35, an earlier referral, at six to nine months of unprotected intercourse, is appropriate. It is true that the average time it takes a 25-year-old woman to conceive is 5.3 months, but that does not address the concern the client is expressing. Choice 4 is still the most caring and correctanswer. Couples conceive within the first month of unprotected intercourse 20% of the time.Health Promotion and Maintenance

NEW QUESTION 480
- (Topic 5)
Which of the following microorganisms is easily transmitted from client to client on the hands of health care workers?

A. mycobacterium tuberculosis
B. clostridium tetani
C. staphylococcus aureus
D. human immunodeficiency virus

Answer: C

Explanation:
Staphylococcus aureus microorganisms are ubiquitous and easily transmitted by health care workers who fail to conduct routine hand washing between clients. Tuberculosis is almost always transmitted by the airborne route, and tetanus usually results from exposure to dirt. HIV is a weak virus that does not live long outside the body.Physiological Adaptation

NEW QUESTION 482
- (Topic 5)
A standard walker is used when clients:

A. have poor balance, cannot stand up, have weak arms, and have good hand strength.
B. have poor balance, have a broken leg, or have experienced amputation.
C. have poor balance, have cardiac problems, or cannot use crutches or a cane.
D. have poor balance, have an autoimmune disease, or have weak arms.

Answer: C

Explanation:
A walker is used for clients who have balance problems, cardiac problems, or cannot use crutches or a cane. The client needs to bear partial weight and have strength in her wrists and arms. The client uses her upper body to propel the walker forward.Basic Care and Comfort

NEW QUESTION 485
- (Topic 5)
The nurse is turning a client who has a new prosthetic hip. Which position should be avoided to prevent injury to the new prosthetic hip?

A. abduction of the hip
B. adduction of the hip
C. flexing the hip at 80?? flexion
D. flexing the hip at 90??

Answer: B

Explanation:
New prosthetic hips should have an abduction pillow in place to avoid adduction.Basic Care and Comfort

NEW QUESTION 490
- (Topic 5)
Which of the following should be included in a diet rich in iron?

A. peaches, eggs, beef
B. cereals, kale, cheese
C. red beans, enriched breads, squash
D. legumes, green beans, eggs

Answer: A

Explanation:
Home sources of iron that can be absorbed in the body include meat, poultry, and fish. In addition, these sources contain a factor that helps to enhance iron absorption of nonheme sources. Eating Vitamin C at the same time as iron sources also helps to promote iron absorption.High calcium intake in the diet promotes the absorption of iron because it helps to bind to phytates and thereby limits their effect.Physiological Adaptation

NEW QUESTION 493
- (Topic 5)
All of the following clients are in need of an emergency assessment except:

A. a bleeding client who has an injury from falling debris.
B. an unresponsive client.
C. a client with an old injury.
D. a pregnant woman with imminent delivery.

Answer: C

Explanation:
The client with an old injury does not need an emergency assessment because this is not a life-threatening or new situation or condition.Safety and Infection Control

NEW QUESTION 498
- (Topic 5)
Client room environments should include:

A. a made bed, fresh water, thermostat regulation, and clean floors in all occupied client areas.
B. a made bed, comfort and safety, a clutter-free area, hygiene articles nearby.
C. accident prevention, comfort, a room (including furniture) that has been cleaned with chloroseptic wash, a bed that is made every other day.
D. odor control (by spraying the room with deodorizers), closet storage of all client objects, a clean roo
E. (Gloves should be worn when cleaning.)

Answer: B

Explanation:
Preparing a client??s room environment should include making the client??s bed, ensuring comfort and safety at all times, keeping the area free of clutter, and keeping the client??s hygiene articles nearby. All procedures should be explained before they are performed, and the client should assist with personal arrangement of articles.Basic Care and Comfort

NEW QUESTION 499
- (Topic 5)
When a woman is receiving postpartum epidural morphine, the nurse should plan to observe for which of the following side effects to occur within the first 3 hours?

A. nausea and vomiting
B. itching
C. urinary retention
D. somnolence

Answer: B

Explanation:
A side effect of postpartum epidural morphine is the onset of itching within 3 hours of injection and lasting up to 10 hours. Nausea and vomiting might occur 4–7 hours after injection. Urinary retention is a side effect of postpartum epidural morphine but is not assessed as such within the first 3 hours. Somnolence is a rare side effect.Health Promotion and Maintenance

NEW QUESTION 502

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